HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE


Digitized by the Internet Archive
in 2016

https://archive.org/details/imjillinoismedic1291illi

LTH SCIENCES LIBRARY
VERSITY OF MARYLAND
BALTIMORE
FEB 2 1966

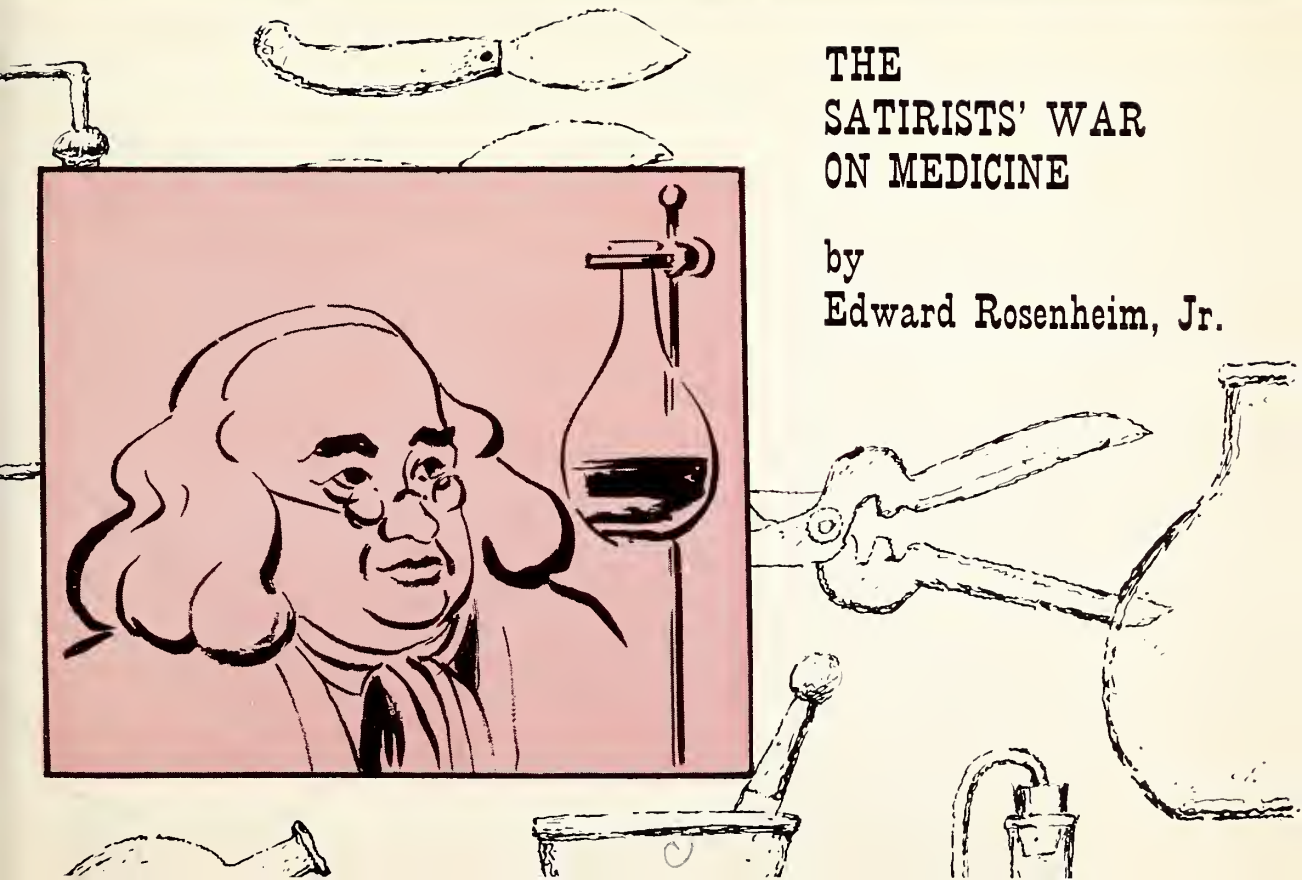
Volume 129, Number 1, January, 1966

STACKS
CIRCULATES AFTER FEB 15 1966

IMJ

Illinois Medical Journal

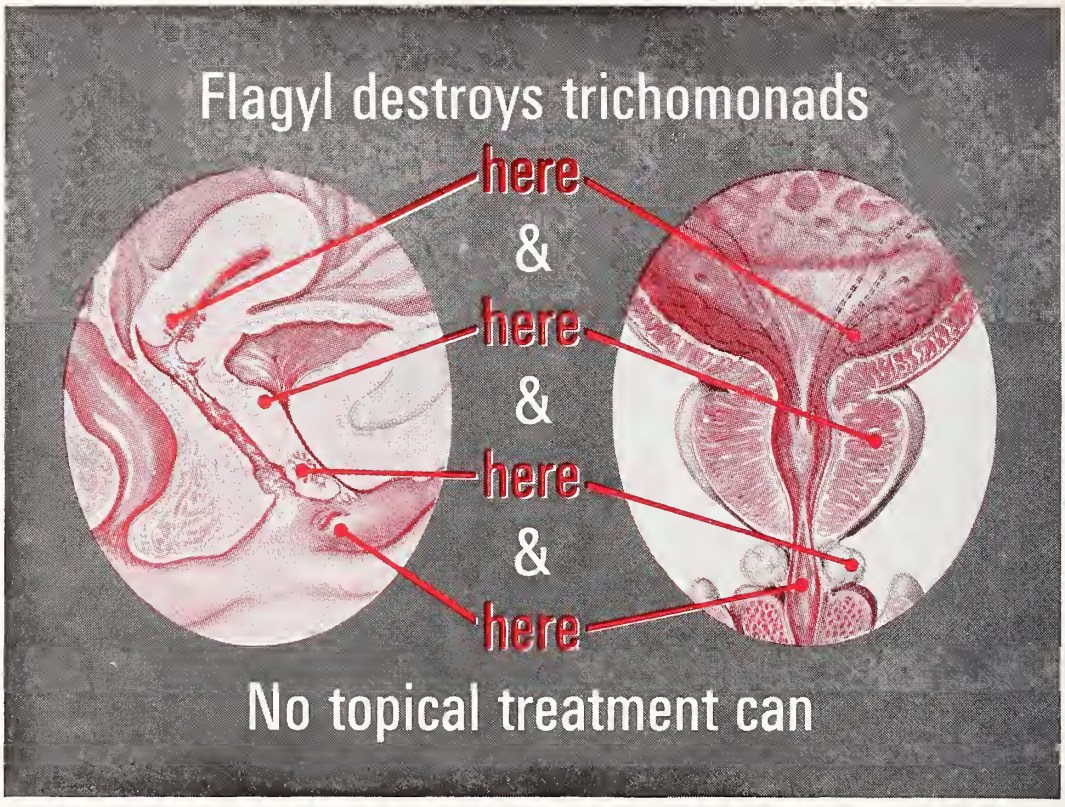
OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY



THE SATIRISTS' WAR ON MEDICINE

by
Edward Rosenheim, Jr.

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE



Flagyl®

brand of

metronidazole

Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection. These difficulties arose mainly from:

1) *the failure of any previously known agent to destroy the protozoan in paravaginal crypts and glands;*

2) *the failure of any previously known agent to prevent reinfection by eradicating the disease in male consorts.*

The introduction of Flagyl removed these deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

Dosage and Administration

In *women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral—250-mg. tablets
Vaginal—500-mg. inserts

SEARLE

Research in the Service of Medicine

IMJ

Illinois Medical Journal

CONTENTS

volume 129, no. 1 *January, 1966*

MEDICAL PROGRESS

Recent Advances: Blood Group Incompatibility of the Newborn
Israel Davidsohn, M.D., Chicago 39

CLINICAL ARTICLES

A Long Term Study of Diabetics Treated with Chlorpropamide
John P. Doenges, M.D., Lawrence J. Knox, M.D. and Charles W. Harrison, M.D., Olney 25

Sporotrichosis
J. William Didcoct, M.D. and Robert L. Wolf, M.D., Urbana 31

Treatment of a Severe Extensive Thermal Burn
Max Klinghoffer, M.D., Elmhurst 33

Massive Bleeding Peptic Ulcer Mortality in the Aged
Enrique T. Yap, M.D., Metropolis 43

The Satirists' War on Medicine
Edward Rosenheim, Jr., Chicago 48

The View Box
Leon Love, M.D., Chicago 55

Endobrachial Lipoma: Report of a Case and Review of the Literature
Victor R. Jablokow, M.D. and Myron E. Rubnitz, M.D., Hines 57

Acute Hemorrhagic Pancreatitis: Beneficial Effects of Primary Excision of Grossly Necrotic Tissue
Lawrence G. Khedroo, M.D. and Philip A. Casella, M.D., Chicago 61

FEATURES

President's Page 6
Editorials 68
Dr. Sims in Action 76
Book Reviews 84
Placement Service 88
IMAA Reports 90
New Products 92
Meeting Memos 95

Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Ill. 60601. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.50 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies available at cost of 75 cents.
Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.
Copyright 1966, The Illinois State Medical Society.

Blood-glucose screening for all your patients?

...because "Abnormalities of glucose metabolism are among the [most common] encountered in clinical practice...."* Simple, quick, economical blood-glucose screening with DEXTROSTIX® Reagent Strips is practicable in every regular physical examination, emergency situation, and whenever hypo- or hyperglycemia may be of clinical significance—for "The precision and accuracy of DEXTROSTIX ...meet the need for an always available simple screening method...."* All that is required for screening with DEXTROSTIX is 60 seconds and a globular drop of capillary or venous blood. Abnormal readings will be a valuable aid to diagnosis; normals will help you establish an important baseline for future reference.

*Marks, V., and Dawson, A.: Brit. M. J. 1:293, 1965.



DEXTROSTIX—
provides a clinically useful determination when performed according to directions†

†DEXTROSTIX is not intended to replace the more precise analytical laboratory methods.

Yes—all your patients

AMES COMPANY, INC.
Elkhart, Indiana



On Stelazine® brand of trifluoperazine she's calm and alert

When a tranquilizer is needed, 'Stelazine' can regulate the level of anxiety so that the patient is unlikely to overreact to stress but is not tranquilized into psychic inertia. Patients on 'Stelazine' often experience a sense of mental alertness and, because they feel so much better, are more interested in their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

Photograph professionally posed.

SK&F

Smith Kline & French Laboratories



Burtis E. Montgomery, M.D.

president's page

ISMS IN AMA

It has been said that the American people love their doctors but hate the AMA. It is sad but true that many physicians do nothing to discourage this attitude and, in some cases, even share this feeling. This point of view is indefensible in the face of the scientific triumphs that have been possible only under the American system of medical practice and is completely illogical on the part of doctors who are themselves the AMA. I am always dismayed when I hear an Illinois physician criticizing the American Medical Association as though it were a thing apart from him, like the government of Iceland or the religious practices of the Hottentots. Because, you see, the AMA is no one but members of the medical profession in the United States and activities on the national level only reflect the opinions of individual members as expressed through delegates elected by the state organizations.

Illinois, being one of the larger states in terms of physician population, exercises influence at the national level in keeping with its proportionate size and the Illinois delegation to the AMA has always played an active role in representing its constituents. The state's influence recently has been at a peak because one of our own, Dr. Percy Hopkins, has been chairman of the AMA Board of Trustees. Now, after long and faithful service to Illinois and to organized medicine as a whole, Percy goes off the Board in June and your president hopes to maintain a voice for Illinois at the national policy-making table.

In addition to your president, another of your Illinois colleagues is a candidate for national office: Dr. Walter C. Bornemeier, former speaker of our House of Delegates, currently vice-speaker of the AMA House and, hopefully, its next speaker.

You should know, too, that many other Illinois doctors are active in organized medicine at the national level. For example, four Illinois men served on reference committees at the recent Philadelphia convention: Dr. Leo P. A. Sweeney, chairman of the Committee on Medical Military Affairs; Dr. Paul H. Holinger, Committee on Amendments to Constitution and Bylaws; Dr. Frank H. Fowler, Committee on Insurance and Medical Service; and Dr. Maurice M. Hoeltgen, Committee on Public Health and Occupational Health.

Also during the Philadelphia meeting, your president had the pleasure of presenting the Illinois State Medical Society's check for $189,000 to the AMA-Educational and Research Foundation. The presentation was made in honor of the first woman member of the AMA, Dr. Sarah Hackett Stevenson, who represented our state at the 1876 convention in Philadelphia.

IMJ

Illinois Medical Journal

volume 129, number 1 January, 1966

A LONG-TERM STUDY OF DIABETICS TREATED WITH CHLORPROPAMIDE

John P. Doenges, M.D., Lawrence J. Knox, M.D., and Charles W. Harrison, M.D./olney

THE PURPOSE OF THIS STUDY is to give a long-term follow-up on patients who have been under treatment for diabetes with chlorpropamide (Diabinese) for three to seven years. The authors had previously reported their experience using tolbutamide and chlorpropamide in a group of out-patient diabetics[1,2]. The previous study had been primarily for the purpose of comparing the hypoglycemic effects of these two oral hypoglycemic agents. It was noted at that time that patients treated with chlorpropamide consistently ran lower cholesterol levels than when they had previously been on tolbutamide therapy. The original study had included 32 outpatients, 22 of whom had previously been treated with tolbutamide. These same cases are again reviewed and in addition 99 new patients have been added to the series, and an attempt will be made to determine the long-term effect of chlorpropamide in this group.

Our interest in this compound has been three-fold. One, is it practical in long-term office regulation of diabetics? Two, what are its toxic effects and what percentage of treatment failures can be expected? Three, does it have a significant effect on the serum-cholesterol level? Many previous studies[3,4,5] have shown the practicality of long-term use of oral hypoglycemic agents and our experience has been quite similar. The only significant difference in our group and those previously published is that the patients are from a rural area and, therefore, from a different occupational and educational level. Normal dietary habits in this type of area frequently differ considerably from that of an urban population. West, et al.,[6] have reported a small group of patients on whom chlorpropamide was used in conjunction with an unrestrictive diet with moderate success. In our previous study, serum-cholesterol levels appeared to

significantly lower on patients treated with chlorpropamide when compared to the same group of patients previously treated with tolbutamide. We had hoped to determine if this lowering of the serum-cholesterol level was a consistent finding in a larger group of patients and if it persisted with longer-term therapy. In the study of Hands, Moore and Masters,[7] using the incorporation of C-14 into free cholesterol it was found that there was decreased incorporation of C-14 into free and esterified cholesterol in diabetics treated with chlorpropamide. However, the serum-cholesterol level appeared to be unchanged and they felt that the processes involved in degradation of cholesterol must be proportionately slowed, resulting in a slower cholesterol turnover.

In the study of Carlson and Ostman[8] on serum-lipid levels, they concluded that the serum glycerides were significantly lowered following chlorpropamide therapy but the response of cholesterol and phospholipids during therapy was quite variable and not related to the chlorpropamide treatment. Other investigators[9,10] have reported a similar variable response of the serum-cholesterol levels and phospholipid levels associated with the use of the oral antidiabetic agents.

Method of Study

Chlorpropamide therapy was given in 131 out-patient diabetic cases. All of the patients included in the study had been on the drug for a minimum of three years to a maximum of seven years, unless they fell into the class of a treatment failure. The age range of the patients was from 27 years to 88 years, and there were 54 males and 77 females. The dosage of chlorpropamide ranged between 0.10 Gm. and 0.75 Gm. No attempt was made to select the cases used except on the basis of severity and age. It has been previously noted[2] that juvenile diabetics did poorly so these patients were automatically excluded, as were diabetics requiring more than 40 units of Insulin per day for regulation. Therapy was continued without interruption throughout the study, unless signs of toxicity appeared or in the event of treatment failures. After initial regulation most of the patients were seen at three-month intervals, unless poor response to therapy or signs of toxicity indicated the need for more frequent visits. Serum-cholesterol determinations, using the method of Pearson, Stern and McGavack,[11] were done periodically. Thymol turbidity studies were done as a screening test for liver disease. Because of the age group involved in this study, many of the patients had other concurrent illnesses (see Table 1) and frequently many of the patients were on other medications in addition to their oral hypoglycemic agent.

Table 1
CONCURRENT ILLNESSES

Pulmonary Embolus	1
Carcinoma, Ovary	1
Coronary Artery Disease	17
Hypertension	14
Cirrhosis	2
Cataracts	1
Carcinoma of Uterus	1
Chronic Glomerulonephritis	1
Tuberculosis	1
Peripheral Neuritis	3
Congestive Heart Failure	6
Cerebrovascular Accident	4
Diabetic Ulcer	2
Diabetic Retinitis	3
Hypothyroidism	1
Reticulin Cell Sarcoma	1
Uremia	1

Results

In this series of 131 cases, who received long-term diabetic management with chlorpropamide, there were 11 cases which were classified as failures. (Table 2). This represents 8.4 percentage of treatment failures. The low incidence of treatment failures was undoubtedly in part due to the selection of cases in which chlorpropamide therapy was instituted. A criteria for selection of patients similar to that of Tomhave[12] was used in this series:

1) Patients over 40 years of age (except in exceptions noted.
2) Previous control of diabetes with either tolbutamide or 40 units of insulin, or less.

Table 2
CAUSES OF FAILURE

1. Unable to control because of severity of Diabetes	7
2. Peripheral Infections	1
3. Poor patient co-operation due to emotional problems, senility, et cetera	2
4. Brain Tumor	1
Total	11

3) Relatively stable diabetics without previous history of repeated episodes of acidosis.

4) Patients with diabetes of recent onset.

Patients with complicating illnesses were acceptable for this series. However, in the event that surgery or other complicating processes arose they were frequently transferred to Insulin during this emergency period and the oral hypoglycemic agent was resumed at the end of the emergency. Fifteen patients had major surgery during the course of this study and were re-regulated on oral medication in the postoperative period. Three patients were well controlled on combined treatment, which included insulin and chlorpropamide. It was felt that these three patients were better controlled on combined therapy than they had been previously on insulin therapy alone. The insulin dosage in these three patients ranged between 30 and 45 units of insulin and this was supplemented with 500 mg. of Diabinese. Of the aforementioned 11 failures, seven of these were considered failures because of poor diabetic control. Blood-sugar levels were consistently above 250, despite doses of chlorpropamide, over 750 mg. daily, and ketonuria was frequently present. Dosages of this magnitude are no longer recommended, but at the time of initiation of this study dosage schedules had not been established and several patients received as much as 1500 mg. of Diabinese per day for short periods of time. When control was not adequate on these massive doses therapy was discontinued. In several of these patients there was very little effort on the part of the patient to control his diet, which further complicated the care of his illness. In the three additional patients it was felt that they could possibly have been controlled, but other complicating factors led to treatment failures. In one of these, repeated extensive infections necessitated the discontinuation of the oral hypoglycemic agent and the use of insulin, and in one patient the presence of a brain tumor necessitated the same course of therapy.

Deaths

Over the seven years included in this study there were 31 deaths among the patients involved. The cause of death and sex distribution is summarized in Table 3. The

Table 3
CAUSES OF DEATH

			M	F
1)	12	Myocardial Infarction	5	7
2)	6	Arteriosclerotic vascular disease with cardiac failure	1	5
3)	2	Nephrosclerosis	0	2
4)	3	Bronchopneumonia	0	3
5)	3	Cardiovascular disease	1	2
6)	1	Leukemia and Polycythemia	1	0
7)	1	Reticulin cell sarcoma	0	1
8)	3	Unknown	2	1

average age of the patients included in the entire study was 65, and the average age at death was 68 for females and 69 for males. It is felt by many investigators that diabetes may be a predisposing factor to cardiovascular disease. However, in our series the incidence of cardiovascular disease as the cause of death closely approximated the incidence of cardiovascular disease in the general population of this age group. Most of the patients in this series became diabetic in later years and the diabetes was well controlled until other illnesses produced death. In six of the patients, acidosis was part of the terminal illness. However, this was frequently associated with a rising blood urea nitrogen, as well as with an elevation of the blood sugar. None of the patients in this series was felt to have died purely as a result of diabetes mellitus, as evidenced by the lack of metabolic complications, nor could any of the deaths be attributed to chlorpropamide therapy. Complications of the dia-

betic therapy were nil except in those previously-mentioned cases in which control was considered inadequate, and this therapy was discontinued. In several instances minimal gastrointestinal symptoms were experienced but were of such a mild nature that therapy was not interrupted, and they subsided after a period of time.

The range of initial blood sugars in this series was from 86 to 401, with an average initial blood sugar of 222.5 mgs. per cent. The average initial serum-cholesterol level was 243.9 per cent, with a range of cholesterol levels between 150 and 523. Blood-sugar levels were done repeatedly throughout the series and serum-cholesterol levels were done at less frequent intervals. At the end of the series the average blood-sugar level was 161.3 mgs. per cent with a range of from 77 to 242, and the final serum-cholesterol level was 208.9 mg. per cent with a range of from 127 to 340. One hundred and six patients in this series were available for serum thymol turbidity studies, either at sometime during the series or at the completion of the series, and in only four of these patients was abnormal liver function detected using this method. Two of these four patients had evidence of congestive failure and it was felt that their liver disease was related to congestive changes. In the other two patients no other explanation for the elevated thymol was apparent except the relative severity of the illness and the use of this type of therapy.

Comment

It was the authors' feeling, after following this group of patients over a period of seven years, that long-term regulation of their diabetes with oral hypoglycemic agents was quite practical. Careful selection of the patients for such management is essential for proper regulation of their disease. If the juvenile diabetic, the diabetic of long standing, who has been on insulin, and the diabetic requiring more than 40 units of insulin are excluded, one can expect a satisfactory response with chlorpropamide therapy. Long-term management of these patients requires simplicity as well as economy, and it was felt this was one of the major attributes of chlorpropamide, in that frequently these patients were adequately controlled with one tablet each day or with single-dose therapy. In the age group involved this was often of major consequence in proper regulation, for many of these patients were approaching the degree of senility which made complex routines unadvisable. In addition to that, the one-tablet or single-dose method of therapy frequently represented a considerable saving. To the elderly patient of limited means this was a major factor in promoting better patient co-operation. An attempt was made with these people to establish a diet pattern and to instruct them in a diet of adequate caloric content to insure their nutrition. However, frequently, because of their previous dietary habits and their relatively lower educational level, it was quite difficult to insure the proper dietary regime. Where there are wide variations in dietary intake, it was of interest to note that we infrequently encountered hypoglycemic reactions and this group of patients as a whole were better regulated on oral medication than they would have been on a more stringent regime of strict diet and insulin. In the study of West, et al., a similar experience using unrestricted diet and chlorpropamide had been reported.

Side-Effects

We did not encounter any serious side-effects from chlorpropamide. Numerous complications have been reported in the literature, including agranulocytosis,[13] perforated ulcer,[14] hepatic damage and jaundice[15] and skin rashes[16]. In the two patients mentioned, in whom an elevated thymol turbidity was found, no other evidence of liver toxicity was apparent, and none of the aforementioned complications were encountered in the present series. It is noted in the results that the average blood-sugar level at the completion of this study was 161.2 mg. per cent and some investigators[17] would suggest that this does not represent adequate control of the disease. However, it was our feeling that in this age group

blood-sugar levels of 150 to 200 mg. per cent represented a more comfortable level for the patient than those patients who were regulated at levels below 150 mg. per cent. Despite blood-sugar levels of this magnitude these patients remained free of significant glycosuria or ketonuria. They did not experience continual hunger and, in general, had a sense of well-being not experienced by those more cautiously controlled.

The patients in this series originated from a wide rural area of approximately 250 square miles. This often made close follow-up both impractical and difficult and a lesser degree of control was felt acceptable.

Serum-Cholesteral Changes

The changes in the serum-cholesterol level experienced in this series remain somewhat of an enigma. In most instances the serum cholesterol levels were significantly higher at the onset than at the completion of the study. However, we remain somewhat remiss to suggest that this is either in part or wholly due to chlorpropamide therapy. Better control of dietary intake of high cholesterol foods, as well as lowering of the blood-sugar level, is undoubtedly in part responsible for the lower cholesterol levels. Despite this, it remains that these patients' cholesterol levels were significantly lowered and, in view of the vascular complications of this illness, this effect is certainly desirable. Further studies on serum-lipid determinations in long-term management with oral hypoglycemic agents may throw additional light on this subject. The major cause of death in this group of patients continues to be the cardiovascular diseases. Whether regulation of serum-cholesterol in this age group is of any significance or not remains to be determined. It is, however, reassuring to know that such therapy is apparently doing nothing to facilitate the progress of the cardiovascular complications.

One patient, a 39-year old white female, who had had severe diabetes for a number of years, became pregnant while under study in this series. She had been poorly regulated on insulin, primarily because of poor co-operation and refusal to take her regular injections, and it was for this reason that she was first started on chlorpropamide. Of course, this is not a recommended indication for institution or oral hypoglycemic agents but, in cases such as these, it is sometimes a necessity in order that the patient have at least partial control of her disease. At the onset of this study her blood sugar was 190, and at the completion of the study it was 193. The thymol turbidity was not significantly elevated and the serum cholesterol ranged between 240 at onset to 230 at completion. This patient had a stillborn baby at seven months but it is impossible to determine whether this stillbirth was in anyway related to the therapy or to the patient's lack of diabetic control. She was poorly regulated on insulin and poorly regulated on Diabenese. However, on the oral medication she did consent to continue on the medication and was on it throughout her pregnancy. At no time did she have acidosis, whereas she had previously had frequent episodes of acidosis because of her refusal to take shots. This was the only patient who became pregnant while under study in this series and no conclusion could be drawn as to the effect of chlorpropamide therapy on the pregnancy. However, this deserves special mention, as fetal damage has been reported as related to chlorpropamide therapy by other investigators[18].

Conclusions

In a series of 131 diabetic patients followed over a period of from three to seven years it was felt that management with the oral hypoglycemic agent, chlorpropamide, was both practical and desirable in selected cases. No serious toxic effects were noted in this series of cases. There was an 8.4 per cent rate of treatment failures. The serum-cholesterol levels of these patients were studied at the institution of chlorpropamide therapy, during and at the end of the period of study, and a significant lowering of cholesterol was encountered. The lowering of cholesterol may, in part, be due to chlorpropamide therapy but it is

also, undoubtedly, related to better regulation of dietary intake.

References

1. Knox, L. J., Harrison, C. W., Doenges, J. P.: *Illinois Medical J.* 112, 201, 1957.
2. Knox, L. J. and Doenges, J. P.: *Amer. J. Med. Sc.* 238, 4 Oct. 1959.
3. Parkers, A. M.: *J. Amer. Geriatric Soc.* XI, 3 March 1963.
4. Bradley, R. F.: *Ann. N. Y. Acad. Sc.* (Vol. No. 82) Yr. 1959, 513.
5. Stewart, R. C., Piazza, E. U., Hyman, H. and Hurwitz, D.: *N.E. Jour. of Med.* 261, (9), 427 Aug. 27, 1959.
6. West, K. M., Top, H. E.: *Metabolism*, Vol. 10, Sept. 1961.
7. Hennes, A. R., Moore, M. Z., Masters, Y. F.: *Metabolism*, Vol. 11, No. 8, Aug. 1962.
8. Carlson, L. A., Ostman, J.: *Acta Media Scandinavica*, Vol. 170 fasc. 5, 1961.
9. Munroe, I. B. and Murray, D.: *Lancet* 2:1083, 1956.
10. Walker, C. and Kinsell, L.: *Metabolism* 4:614, 1959.
11. Pearson, S., Stein, S. and McGavack, T. H.: *Ann. Chem.*, 25, 813, 1953.
12. Tomhave, W. G.: *Med. Clinics of North America*, Vol. 47, Jan. 1963.
13. Karlin, Harold: *New England J. of Med. Vol.* 262, No. 21, May 26, 1960.
14. Alpert, Samuel: *N. Y. State J. of Med.*, July 1, 1962.
15. Reichel, Jos., et al.: *Amer. J. of Med.* Vol. 28, p. 654, April 1960.
16. Hitselberger, James F. and Fosnaugh, R. P.: *J.A.M.A.*, April 7, 1962, Vol. 180 No. 1. .
17. Hadden, David R., et al.: *Diabetes* Vol. 11 No. 2, Mar-Apr 1962.
18. Campbell, G. D.: *British Medical J.* Jan. 5, 1963.

RESULTS OF PROTEIN DEFICIENCY IN CHILDREN

Children living on a diet deficient in protein have a subnormal rate of growth. They have now been found to have an impairment in their delayed hypersensitivity response, even when they have no clinical signs of kwashiorkor. Moreover, the degree of impairment was directly related to the weight of the child as a percentage of its expected weight for age. The impairment of the reaction was not absolute, because it was overcome by increasing the test dose of tuberculin from 2 t.u. tuberculin produced indurations of 15mm. or more to 20 t.u. The tuberculin reaction was still reduced even when it was repeated after a longer period; hence it seems to have been permanently impaired rather than merely retarded. The reaction may be repaired, however, by a short period of good nutrition, since, as previously reported, two children with no response to 2 t.u. tuberculin after B.C.G. vaccination were brought into the ward and given a diet containing 4 g. of protein per kg. of bodyweight, and, when the Mantoux test was repeated at the end of 2 weeks, both produced reactions of 10 mm. (Harland and Brown 1965).

These findings suggest that undernourished children, suspected of having tuberculosis, should be tested with a strong dose of tuberculin, and that, if negative, the test should be repeated after the protein deficiency has been treated. The effects of treatment have been found similar to those of Axelrod and Trakatellis (1964) who demonstrated that animals with growth failure due to pyridoxine deficiency did not respond to tuberculin until the deficiency had been corrected. A failure to respond may be part of a failure to grow, from whatever cause, and this should be taken into account in interpreting the results of a test. Harland, Tuberculin Reactions in Malnourished Children. *The Lancet* (Oct. 9) 1965.

SPOROTRICHOSIS

J. William Didcoct, M.D., and
Robert L. Wolf, M.D./urbana

SPOROTRICHOSIS, A CHRONIC DEEP FUNGUS infection caused by Sporotrichum Schenckii, is a universal disease, and in North America is most common in the North Central United States.[1]

This fungus exists in nature as a closely adherent, moist mat on plants and wood, and the most common route of infection is by inoculation with a contaminated thorn or splinter, producing the localized lymphatic or chancriform syndrome.[1,2]

The chancriform syndrome is characterized by a primary nodule at the site of inoculation, and secondary nodules along the course of the lymphatics draining the area. In sporotrichosis, these nodules eventually ulcerate and discharge a thin pus.

Other deep fungi, such as Coccidioides immitis and Histoplasma capsulatum, grow in soil as fragile, fluffy mats, so in most cases give rise to infections which are initially respiratory, although they, too, have produced the chancriform syndrome in cases of accidental inoculation. Other less common causes of the syndrome include tuberculosis and syphilis.[2]

The clinical appearance of this syndrome should make one immediately think of sporotrichosis as the most likely cause, and the pus should be planted on Sabouraud's glucose agar. In a few days, the typical brown to black, leathery colonies form.[3]

Although the lymphangiitic response to the infection represents the development of a high degree of immunity on the part of the host, it is felt that most cases of sporotrichosis would persist if left untreated. The most satisfactory results are obtained with potassium iodide, although isolated cases have been cured with griseofulvin, antimalarials and other nonspecific remedies, including even hot water soaks.[2,4]

Report of Cases

In the past 16 years, two cases of chancriform sporotrichosis have been seen at Carle Clinic, and both these cases have been seen in the past two and one-half years.

Case 1. An 18 year old white male student received a slight scratch on the little finger of the right hand during an automobile accident in February, 1962. Shortly thereafter, this area was again scratched by a fork while washing dishes, and he later noticed a lump in the area. He consulted a physician, who believed he had a bacterial infection, and was treated with one, then another antibiotic with no improvement. A month later he had developed a chain of nodules up the arm. Bacterial culture was taken which showed staph albus, sensitive to chloramphenicol, novobiocin, Aureomycin, and erythromycin. X-ray of the finger showed some irregularity of the soft tissue, but no bony abnormality.

Panalba and Ilosone were given, and the patient also received whirlpool baths, all to no avail.

The patient was seen by one of us (JWD) on March 24. At this time he had a 2 cm granulating lesion on the side of the right little finger, and two lines of nodules extending up the forearm, one on the dorsal and one on the volar side. Initial impression was sporotrichosis, which was confirmed by culture.

The patient was started on saturated

solution of potassium iodide, five drops tid, increasing by one drop tid daily to a total of 10 drops tid, then by two drops per dose each day to a total of 20 drops tid.

By April 12, the primary site was reduced by 30-40%; and the nodules on the arm were flatter, less inflammatory and less tender.

By May 18, the primary site was completely healed and the nodules on the arm were only barely palpable.

By June 7, the nodules were absent. SSKI was reduced gradually over the next month and then discontinued.

On October 23, 1962, there was no evidence of recurrence. The only sign of previous infection was a scar on the finger.

Case 2. A 65 year old white male farmer first developed a tender nodule overlying the proximal interphalangeal joint of the right index finger in November, 1963. He knew of no preceding injury. Soon thereafter, he developed a chain of superficial purulent nodules extending up the dorsum of the right forearm, and onto the inner aspect of the upper arm. He was treated with a number of antibiotics and the condition improved slightly over a five-month period.

He was first seen by one of us (RLW) on April 16, 1964. At this time he presented the typical picture of chancriform sporotrichosis. Pus from a fluctuant nodule on the arm was planted on Sabouraud's glucose agar, and in a few days, the typical black colonies appeared.

He was placed on SSKI, 10 drops tid, increasing by five drops tid daily to a total of 40 drops tid as maintenance dose. He showed steady improvement, all nodules becoming dry and progressively flatter, but in late June he had an episode of hematemesis, which was believed to be associated with a diaphragmatic hernia and he was taken off the SSKI by another physician.

He was seen again on July 20, and in spite of lack of treatment for several weeks, he had shown continued improvement. The nodules of the arm were now absent, and he had only scarring and slight thickening at the site of the primary inoculation. A trial of hot water soaks, griseofulvin and finally, resumption of the SSKI produced no further change. Treatment was stopped in September, and as of April, 1965, he has had no further difficulty.

Summary and Conclusions

A patient who has an apparent abscess on the finger, with secondary nodules along the course of the draining lymphatics, should alert the physician to the possibility of sporotrichosis.

If the discharge is planted onto Sabouraud's glucose agar, the black, leathery colonies of Sporotrichum Schenckii will appear in a few days.

As is illustrated by the two cases presented, the disease is often mistaken for a bacterial infection, and treated futilely with a series of antibiotics, to the frustration of the physician and the financial despair of the patient.

Potassium iodide is the recommended treatment.

References

1. Conant, N. F., Smith, D. T., Baker, R. D., Callaway, J. R., and Martin, D. S.: *Manual of Clinical Mycology*, Ed. 2, Philadelphia, W. B. Saunders Company, 1954.
2. Wilson, J. W.: Cutaneous (Chancriform) Syndrome in Deep Mycoses, *AMA Archiv. Derm.* 87:81-85, 1963.
3. Hazen, E. L., and Reed, F. C.: *Laboratory Identification of Pathogenic Fungi Simplified*, Ed. 2, Springfield, Illinois, Charles C Thomas, Publisher, 1960.
4. Allende, M. F.: (Report on) The Fifth Ibero Latin-American Congress of Dermatology, *AMA Archiv. Derm.* 89:783, 1964.

Mark Your Calendar Now

ISMS 126th ANNUAL CONVENTION

May 15-18, 1966 ***Sherman House, Chicago***

TREATMENT OF AN UNUSUAL EXTENSIVE THERMAL BURN

Max Klinghoffer, M.D./elmhurst

The purpose of this paper is not to discuss the details of treatment of severe thermal burns since these principles are well established. Rather, it is our purpose to describe a somewhat unusual case of survival in a very extensive severe thermal burn; to discuss the results obtained by using a proteolytic enzyme for medical debridement; and to describe a simple mechanism for earlier mobilization and for rehabilitation of the burn patient.

Early in the morning of September 2, 1963, a 23-year-old man sustained burns over his entire lower extremities from toes to hips; burns of the buttocks and lumbosacral area of the back; burns of both arms from fingertips to shoulders; burns of the abdominal and chest wall anteriorly and laterally. He also sustained multiple contusions, abrasions and lacerations and a fractured fibula. While driving along one of the expressways his car collided with the abutment of an overpass and almost immediately burst into flames. The victim was unable to free himself from his seat belt* and was trapped in the burning vehicle. He was rescued by passers-by who rolled him on the ground to extinguish the flames. When brought to the emergency room of Memorial Hospital, Dupage County, the patient was in severe shock and appeared to be terminal. His condition was so precarious at the time of admission that it was felt nothing more should be done at that time than to combat shock and institute measures to prevent infection. With considerable difficulty a vein was found in the arm and a needle was inserted through the burned tissue. The patient was given large volumes of plasma expander and electrolyte fluids during the first 48 hours. By the second day the problem in administering intravenous solutions was so grave that a consultant was called in to do a cutdown in the inguinal area and to place an in-dwelling catheter in the vessel for administration of fluids. This catheter was left in place for several weeks since no other area was available for intravenous medication.

Debridement Started

Because of the fact that the patient had numerous episodes of shock and coma during the first several weeks, it was not considered advisable to take him to the operating room. Therefore, debridement was started on September 7, 1963 in the patient's room and using only narcotics to

*This is not meant in any sense to downgrade the value of seat belts in prevention of serious injuries. The situation of an accident victim being trapped in a burning vehicle is unusual statistically and there can be no doubt that seat belts generally offer great protection.

control the pain. With the initial debridements, large burned areas of eschar were removed from all the burned areas and were particularly dense over the lower extremities. As these eschars were removed, superficial veins which had been involved in the burned tissue were removed with the eschar. Some of these sections of vein were intact in their entire length and were completely obliterated by the heat. The burns were of such depth as to involve tendons and to expose some of the periosteum of the tibia on both legs. In addition to the daily administration of plasma expanders, electrolyte fluids and antibiotics, the patient also received whole blood as indicated when the hemo concentration was controlled and anemia became a problem. A total of 35 units of blood was given. With each transfusion the patient received an injection of immune globulin in an effort to prevent homologous serum jaundice. Whether due to good fortune or to the use of immune globulin, the patient did not become jaundiced during the course of his stay in the hospital.

On September 22, 1963, the patient began to have severe epigastric pain with hematemesis. A Curling's ulcer was diagnosed and the patient was placed on routine treatment for this by means of diet and medication.

Debridement was done almost daily, with only an occasional day omitted due to the patient's condition. The patient sat up in a semi-reclining position in his bed for the first time on October 8, 1963. It was immediately apparent that postural hypotension would be a serious problem as the patient began to recover. By October 19, 1963 it was felt that the patient could safely be transferred to a Stryker frame. This facilitated the local care of the burns and also later expedited the use of a mechanical device for the rehabilitation period.

One of the major problems in the care of this patient was the matter of hygiene. The wounds were irrigated with modified Dakin's solution but each irrigation and each debridement meant hours of work on the part of a team of doctors and nurses because of the difficulty in moving the patient.

His pain and anxiety were controlled by a combination of tranquilizers and narcotics, with the narcotic dosage being decreased as early as possible to prevent addiction. By November of 1963 the areas of the chest and upper extremities had begun to show substantial healing. However, the lower extremities and buttocks were still grossly infected and a second problem became apparent as the legs developed considerable lymphedema. At this time amputation of the lower extremities was seriously considered as a possibility but fortunately this did not prove necessary.

Physiotherapy was started in March 1964 in the patient's own room. This consisted of active and passive motion of the upper extremities and early attempts to dorsiflex the feet to prevent foot drop.

Skin grafts were started as early as it was considered possible to give the patient an anesthetic. Initial skin grafts were taken from the patient's brother and these served for many weeks to cover the denuded surfaces. After this, skin was taken from the patient's own flanks and lateral chest wall. Each of the first several skin grafts posed a crisis in the operating room because of the patient's very labile blood pressure. It was necessary to observe the patient for hours after each surgical procedure because of shock reaction.

Control of Infection

The mixed infection of the lower extremities continued well into 1964 and debridement was necessary at frequent intervals. This infection also increased the problem of skin grafting from the standpoint of sloughing of the new skin. In May 1964 it was decided to attempt to control some of the infection and necrotic tissue by use of an enzyme antibiotic ointment (containing per gram proteolytic enzymes 10,000 units, neomycin palmitate equivalent to 3.5 mg. neomycin in a special water soluble base).* This material was supplied

*Biozyme Ointment, Armour Pharmaceutical Company, Kankakee, Illinois.

Progress of Thermal Burn Treated With Antibiotic Enzyme



Figure 1: Lateral view showing areas of ulceration and infection prior to use of antibiotic enzyme ointment.

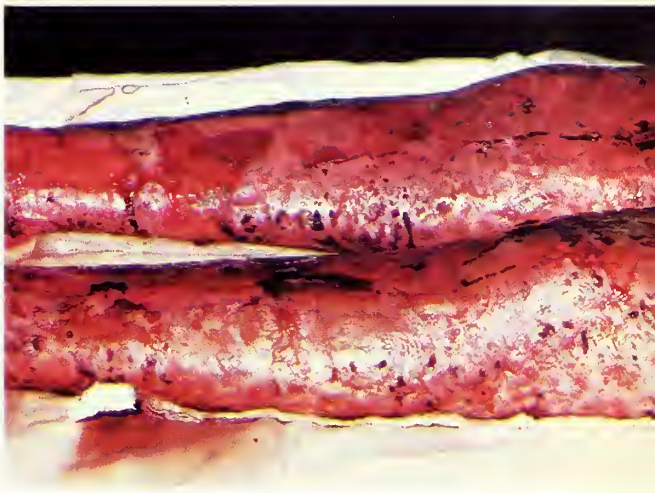


Figure 2: Antero-lateral view of lower extremities showing marked lymphedema and infection before application of antibiotic enzyme ointment.



Figure 3: Improvement following three weeks use of antibiotic enzyme ointment.



Figure 4: Three months after initial use of antibiotic enzyme ointment. Multiple grafts have been performed.

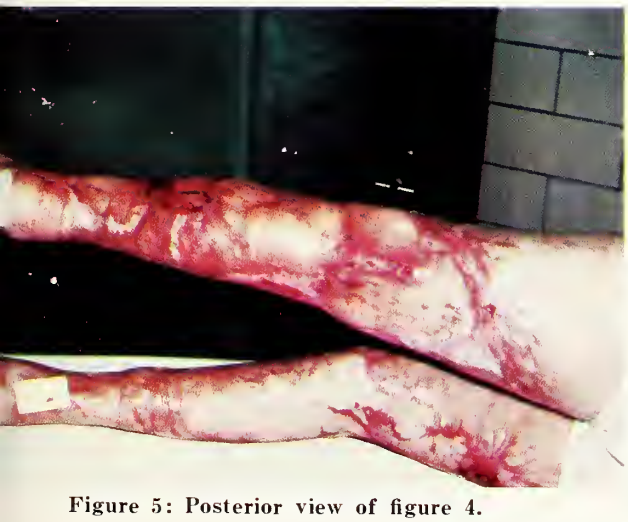


Figure 5: Posterior view of figure 4.



Figure 6: Approximately one year after the burn occurred. All burn areas are now closed and lymphedema is minimal.

Photos; Mr. Leonard Graf, Memorial Hospital, Du Page County

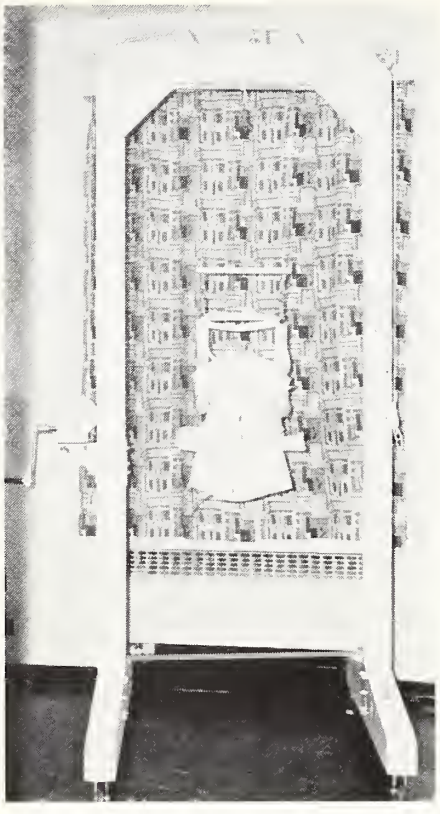


Figure 7: Front view of the lifting device showing the fitted jacket, suspension lines and winch.

Rehabilitation With Stryker Frame and Harness

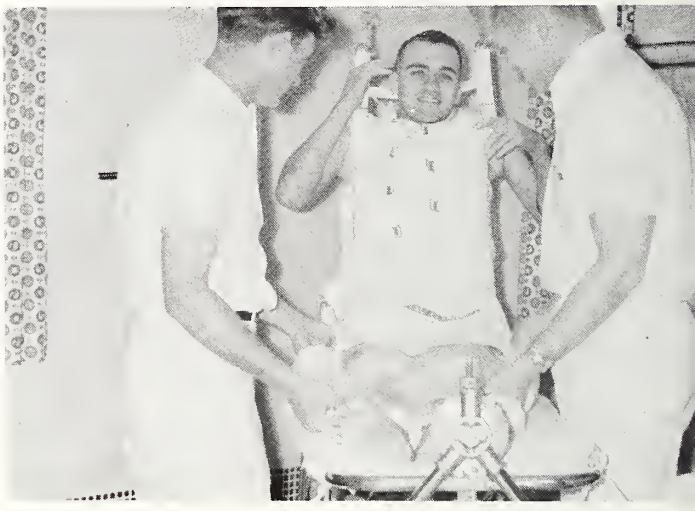


Figure 8: Patient has been raised to the point where his buttocks are free of the Stryker frame. The attendants are lifting the lower extremities preparatory to removing the Stryker frame.



Figure 9: Use of the suspension frame and a walker for correcting foot drop and for rehabilitation.

to us by the Armour Pharmaceutical Company, and with the full understanding of the patient, was applied to only one leg at the beginning. Within a few days, it was apparent that this was producing a profound improvement on the treated leg and it was decided to use the enzyme ointment on both lower extremities. Photographs taken reveal the marked contrast and the improvement of the tissues with the enzyme antibiotic ointment (Figures 1-6). This was continued until the legs were completely clear of infection and we were able to successfully graft skin over the denuded areas. Nevertheless, lymphedema remained a very serious problem until the middle of 1964.

Rehabilitation Course

Many methods were attempted early in the course of this case to enable the patient to sit up and to gradually rehabilitate himself. None of these was successful because of the extremely large area involved in the burns, the depth of the burns and the debility of the patient. For the purpose of rehabilitating the patient, a device was built by the maintenance personnel of Memorial Hospital based upon a similar device with which we had experimented during World War II. This device consists of an overhead frame which can be moved over a bed or Stryker frame. It is mounted on parallel supports with casters which may be locked in position. From the cross-bar of the frame, by means of pulleys, a wire cable and hook may be applied and controlled by means of a winch mounted on one of the uprights of the frame. The assembled structure has somewhat the appearance of a gallows or a guillotine and became fondly known to the hospital personnel by these terms (Figure 7). It is obvious, of course, that such a method of mobilizing the patient can be used only if there are no serious burns on the chest and upper extremities or if these burns are reasonably well healed. In the case described, burns of the upper extremities and chest were almost completely healed by April 1964.

A special jacket, resembling a restraint jacket, but without sleeves, was constructed by an orthopedic appliance house. There were loops built into the jacket to accommodate a hook suspended from the wire on the frame. By means of this mechanism it was possible to move the support over the Stryker frame near the head of the patient. The hook was then engaged in the loops of the jacket and the winch was slowly cranked to bring the patient toward a sitting position.

Patient Sits Up

Several weeks were required before we could move the patient to more than a semi-reclining position due to the problem of postural hypotension. Ultimately, however, we were able to lift the patient to the point where his buttocks cleared the Stryker frame (Figure 8). By gradually increasing the extent of elevation each day, we were ultimately able to swing the patient's legs free of the Stryker frame. Again, it was several weeks before we could lower the legs toward the floor—again because of a shock reaction. Ultimately, we were able to lower the patient's feet to the floor, but only for short periods of time due to hypotension, lymphedema, and extreme cyanosis of the toes. A short time later the patient was able to use a walker or canes to help support himself so that all of his weight was not supported by the frame device. By means of this mechanism we were able to maintain hygiene of the patient and to keep the bedding much cleaner. The patient was then taken to Physiotherapy daily and the frame was used there to enable him to gradually overcome his foot drop. This is accomplished by raising the patient from the Stryker frame, removing the Stryker frame from under the patient and then allowing him gradually to touch the tips of his toes to a sheet on the floor. Each day this was increased slightly so that ultimately the patient was placing the entire foot flat upon the floor. The foot drop gradually disappeared and as motion was increased the lymphedema of the lower extremities also decreased (Figure 9).

By August 1964 the patient was able to move about using a walker or two canes and he was dismissed from the hospital at this time until November 1964. In November 1964 the patient was readmitted to the hospital for about 10 days for further skin grafting. He was also admitted for several days in April 1965 and further skin grafting was accomplished.

The patient resumed his job early in 1965 and is able to walk about without the use of the cane at present. Most of the lymphedema has disappeared and the patient has no particular discomfort at this time. His only complaints at present involve the fragility of some of the areas where skin grafting was done, especially over flexor and extensor areas near the joints.

Summary and Conclusion

A case of survival with unusual extent and depth of burns is described. Also described is the use of an enzyme ointment for the purpose of medical debridement of burns.

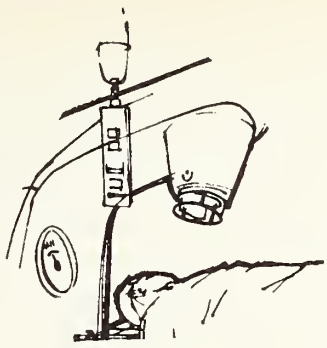
A simple inexpensive device is described for the early mobilization of such patients and for their rehabilitation. While we have not used the mechanism for other purposes, it occurs to us that it might be valuable in restoring function of the lower extremities in many other types of disability involving, for example, severe foot drop.

CHRONIC OBESITY

Appraisal of the gross and microscopic anatomy of the heart was carried out at necropsy in 12 subjects (six men, six women) with marked chronic obesity. In each case the observed heart wieght was considerably greater than that predicted at ideal body weight. Nine of the 12 subjects were found to have increase in left ventricular wall thickness and two, increase in right. The increases in heart weight and ventricular wall thickness were due to muscle hypertrophy involving the left ventricle or both left and right ventricles. Neither isolated nor predominant right ventricular hypertrophy was observed.

It has been concluded that myocardial hypertrophy is a more specific and significant anatomic alteration in the hearts of very obese subjects than are the previously reported findings of excess epicardial fat and fatty infiltration of the myocardium. The relationship between chronic augmentation of the work of the heart in these subjects and the development of cardiac hypertrophy has been discussed. The findings in this study have been interpreted as providing further support for the propositions that manifestations of myocardial insufficiency do occur in very obese subjects with evidences of other heart disease, that these manifestations are those of predominant left ventricular or biventricular failure and that isolated cor pulmonale does not develop in the absence of pulmonary embolization. *Circulation*, November, 1965.

Medical Progress



HARVEY KRAVITZ M.D./progress editor

RECENT ADVANCES:

BLOOD GROUP INCOMPATIBILITY OF THE NEWBORN

Israel Davidsohn, M.D./chicago

It is now 25 years since the Rh factor was discovered. The benefits derived from the studies on the relation between blood groups and hemolytic disease of the newborn (HDN) represent a proud era in the history of modern immunohematology.

At first the emphasis was on the treatment of the anemia. Then came the recognition that jaundice is the more significant and the more dangerous aspect of the disease. It was at that strategic moment that the exchange transfusion was introduced and made it possible to prevent kernicterus and to reduce its incidence considerably.

Many interesting observations have been reported in the course of time, at an ever accelerating pace.

From the more recent advances I have selected four that are concerned with important clinical applications to the diagnosis, prognosis, and prevention of hemolytic disease of the newborn. They are:

1. Prenatal diagnosis and prognosis.
2. Intrauterine transfusion.
3. Prevention of Rh sensitization.
4. Only peripherally related to our topic, but important in the differential diagnosis, is the bilirubin encephalopathy resulting from causes other than blood group incompatibility.

Prenatal Diagnosis and Prognosis of HDN

Until relatively recently, antenatal prediction of HDN was possible to some extent only when the disease was caused by Rh incompatibility. In the case of ABO erythroblastosis, prediction was not possible.

Recently through the use of amniocentesis, prenatal diagnosis of HDN has become more dependable.

Director, Department of Pathology, Mount Sinai Hospital, Chicago; Professor of Pathology and Chairman of Department, Chicago Medical School.

The technique of paracentesis has been adequately described and some of its difficulties have been established. In the experience of some writers, amniocentesis was successful in 95 per cent of attempts, and blood stained specimens were obtained in only 5 per cent of successful taps. Patients did not complain and there were no complications in 500 patients[1].

In cord serum, normal bilirubin does not exceed 2.38 mg. and hemoglobin 13.9 mg/100 ml. of serum[2]. In the amniotic fluid, the highest normal bilirubin was reported by Bevis[2] as 0.42 mg. and hemoglobin as 1.67 mg./100 ml. Others reported 0.035 as a high normal value, and 0.035-0.060 as borderline values[3]. If hemoglobin is normal but bilirubin is elevated, HDN is probable. If both are significantly increased, kernicterus is impending.

Severe hemolysis in the amniotic fluid obtained before the thirty-second week points to a probable fatal termination.

In 101 sensitized Rh-negative women amniocentesis permitted an accurate prediction in 94.0 per cent if the test was done between the thirty-second and thirty-fifth week of pregnancy[4].

Correct Predictions

In another recent report the examination led to a correct prediction in 91 per cent of 142 patients. When the husband was homozygous Rh-positive, the accuracy was 96.4 per cent but only 84.7 per cent when he was heterozygous. When the paracentesis was done before the thirty-fifth week, the forecast was correct in 92.6 per cent, but only in 80 per cent after the thirty-fifth week. This was explained by rapid disappearance of bilirubin after the thirty-fifth week[1]. Others reported that the test retains its value even after the thirty-fifth week, and that the drop in bilirubin is gradual. According to some recommendations, it is preferable to examine specimens that are as fresh as possible. They should be protected against light and kept frozen if waiting is necessary. However, others found that sterile specimens protected from light kept well with or without refrigeration and could be sent by mail.

According to Halverson and Finne,[5] detection and quantitative estimation of *erythropoietin* in amniotic fluid promises to provide valuable prognostic information. The level of erythropoietin was measured by the uptake of radioactive iron (Fe^{59}) by erythrocytes in mice made polycythemic by transfusion. Normal newborn infants have slightly elevated plasma erythropoietin (from 0.5 - 0.9 Fe^{59}%) while in severely anemic erythroblastic infants erythropoietin levels may be greatly elevated (ranging from about 2 to 34 Fe^{59}%).

Progress has also been reported in prenatal diagnosis and prognosis of ABO HDN as distinct from the Rh disease. *A or B* incompatibility is responsible for about two thirds of the cases of fetal erythroblastosis, which are in most cases, clinically mild, but jaundice, if associated with excessively high serum bilirubin levels, may damage the brain as severely as in Rh incompatibility. Rh incompatibility causes only about one third of the cases of the disease, but includes more than 90 per cent of those severely affected. Many other blood factors may be involved, but all of them are responsible for only from 2 to 3 per cent of all cases of the disease.

The recent advances in the prenatal diagnosis and prognosis of the ABO HDN are the outgrowth of the well known observation that in ABO heterospecific pregnancy, in which the fetus has the A or B factor and the mother does not have it, the serum of the mother may have hemolysins for red cells with the factors A or B. However, such hemolysins are not necessarily an indication of erythroblastosis due to A or B incompatibility nor does their absence exclude the disease. Recently, it was found that hemolysin against human red cells of group A has the ability to hemolyze also red cells of the pig which have a factor identified as A^p. It was reported that in ABO hemolytic disease of the newborn, absorption of anti-A hemolysin with pig erythrocytes of group A^p permitted separation of women with an ABO incompatible

pregnancy into three groups. Those with a strong reaction in the antibody absorption test (A-A test) gave birth to severely affected infants, practically all of them requiring exchange transfusions. Only 50 per cent of the infants whose mothers gave a moderately positive A-A test required exchange transfusions, and none were needed for the infants of mothers with a weakly positive test[6]. This observation awaits confirmation.

Intrauterine Transfusion

Exchange transfusion has been a great advance in the treatment of HDN and in prevention of kernicterus, but premature delivery has been the only means of preventing stillbirth. Attempts to reduce perinatal mortality caused by fetal hydrops by early termination of pregnancy have been handicapped by the prematurity of the newborn.

Of 7 perinatal deaths in 80 consecutive Rh sensitized pregnancies reported by Liley, 6 were hydropic before 34 weeks' gestation. In the intrauterine transfusion, packed erythrocytes are injected with a needle introduced through the abdominal and through the uterine wall of the mother, then through the abdominal wall and into the peritoneal cavity of the fetus. Intrauterine transfusion will not restore the fetus to normal, but permits to arrest further deterioration, and to gain a few extra weeks of gestation and thus reduces prematurity[7].

There have been encouraging confirmatory reports on the operation. At a recent meeting (3/19/65) of the Chicago Gynecological Society, Liley reported 44 successful intraperitoneal transfusions in 31 cases[8].

Levine reported in 1943 that Rh antibodies are much more likely to develop in ABO homospecific pregnancies than in heterospecific pregnancies[9].

Stern et al. confirmed experimentally Levine's statistical observations[10]. Injection of Rh-negative men with Rh-positive blood was approximately 6 times more likely to result in production of Rh-antibodies when the blood was ABO-compatible for the recipient, than when it was ABO-incompatible.

An important advance is a recently published method with which it is possible to demonstrate fetal red cells in the blood of the mother when the test is done after delivery. Women in whom only a few fetal red cells were found did not develop Rh antibodies, while 66% of those with a significant number of fetal cells showed Rh antibodies when examined 3 months later. These observations led to experiments in which A Rh + (CDe/cde) red cells tagged with Cr^{51} were injected into A Rh male recipients. Three minutes later, some of the recipients were given an antiserum containing antibodies for the Rh factor. After three hours those that received the antiserum had less than half of the number of Rh-positive red cells that were present in the men who did not receive the antiserum. This experiment suggested prophylaxis against Rh sensitization.

The recommended procedure is as follows: in a primigravida with an Rh + infant, blood smears of capillary blood from a finger or an ear lobe should be prepared immediately after the delivery of the placenta and the amount of fetal blood should be determined. If the result indicates that more than 40 mm^3 of fetal blood entered the maternal circulation, then the mother should be given from 12 to 25 ml. of ABO compatible high titered anti-D serum. The expected result is that the injected serum will cause removal of the Rh-positive cells from the circulation and prevent development of Rh antibodies. In a recent report of Preisler and Schneider published in December 1964, experiments are mentioned to determine if gamma globulin fractions could be used to prevent hepatitis[11].

Other Hemolytic Disease of the Newborn

It has been known for years that prematurity alone without blood group incompatibility may be the cause of kernicterus and of its sequelae. It was reported recently that glucose-6-phosphate dehydrogenase (G-6-PD) deficiency in red cells may be responsible for hemolytic anemia and severe

neonatal jaundice and kernicterus. There are differences between kernicterus caused by blood group incompatibility and by enzyme deficiency. In the disease caused by enzyme deficiency, jaundice does not appear until after 24 to 48 hours and even later. Hepato- and splenomegaly are rare.

The enzyme deficiency is genetically determined. It is estimated that more than 100,000,000 people are affected. The enzymatic deficiency by itself does not produce the disease. It is responsible for the hypersensitiveness to a variety of chemicals which trigger the hemolysis and anemia. Drugs, transmitted via breast milk of mothers, and exposure to mothballs have been responsible for precipitating an attack in many instances.

An interesting study was published recently from Toronto[12].

Summary

Research on blood group incompatibility between mother and fetus has resulted in the reduction of perinatal mortality, first by the treatment of anemia, then by prevention of kernicterus. Recent advances have opened new possibilities by permitting specific prenatal diagnosis with the help of amniocentesis, and by reducing the hazard of prematurity with intrauterine blood transfusion. It is possible that prevention of sensitization to the Rh factor which had been tried unsuccessfully many times in the past, may finally become a reality.

Factors other than blood group incompatibility and, specifically, a genetically determined enzyme deficiency of red cells may be responsible for bilirubin encephalopathy.

References

1. Walker, A. H. C. and Jennison, R. F.: Antenatal Prediction of Hemolytic Disease of Newborn. Comparison of Liquor Amnii and Serological Studies, *Brit. M. J.* 2:1152, 1962.
2. Bevis, D. C. A.: Blood pigments in Haemolytic Disease of the Newborn, *J. Obst. Gynaec. Brit. Emp.* 63:68, 1956.
3. Stewart, A. G., and Taylor, W. C.: Amniotic Fluid Analysis as an Aid to the Antepartum Diagnosis of HDN, *J. Obst. & Gynaec. Brit. Emp.* 71:604, 1964.
4. Walker, A. H. C.: Liquor Amnii Studies in the Prediction of Haemolytic Disease of the Newborn, *Brit. M. J.* 2: 376, 1957.
5. Halverson, S., and Finne, P. H.: Transfer of Erythropoietin to Amniotic Fluid in Rh-Immunized Pregnant Women, *Brit. M. J.* 1:1132, 1963.
6. Tovey, G. H., Lockyer, J. W., Blades, A. N., and Flavell, H. C. G.: Ante-Natal Prediction of ABO Haemolytic Disease, *Brit. J. Haemat.* 8:251, 1962.
7. Liley, A. W.: Liquor Amnii Analysis in the Management of the Pregnancy Complicated by Rhesus Sensitization, *Am. J. Obst. & Gynec.* 82:1359, 1961; Intrauterine Transfusion of Foetus in Haemolytic Disease, *Brit. M. J.* 2: 1107, 1963.
8. Kravitz, H.: A Post-Lileyan View of Erythroblastosis, *Ill. Med. J.* 127:583, 1965.
9. Levine, P.: Serologic Factors as Possible Causes in Spontaneous Abortion, *J. Hered.* 34:71, 1943.
10. Stern, K., Davidsohn, I., and Masaitis, L.: Experimental Studies on Rh Immunization, *Am. J. Clin. Path.* 26:833, 1956.
11. Preisler, O., and Schneider, J.: An Attempt to Prevent the Sensitization of Rhesus-Negative Mothers by Injection of Anti-D Serum, *German Med. Mthly.* 9:496, 1964.
12. Naiman, J. L., and Kosoy, M. H.: Red Cell Glucose-6-Phosphate Dehydrogenase Deficiency—A Newly Recognized Cause of Neonatal Jaundice and Kernicterus in Canada, *Canad. M. A. J.* 91:1243, 1964.

THE HAZARDS OF THE MOTORCYCLE

The hospitals of Minneapolis have recently released meaningful statistics on "the hazards of the motorcycle." In a period of three and a half months, 200 victims of motorcycle accidents were treated. "All but six of those hurt were riding lightweight vehicles." Eighty per cent of the injured were males; 50 per cent of the victims were passengers; and most of them were between the ages of 15 and 25. There were 119 minor injuries, 72 major ones and two deaths, both from skull fracture with brain injury. Sixty-two per cent of the accidents were car-motorcycle collisions, and most of the rest were upsets. Clearly, "the public should be made aware of the hazards of motorcycle operation." Editorial Capsules. *Med. Tribune.* (October 9-10) 1965.

MASSIVE BLEEDING PEPTIC ULCER MORTALITY IN THE AGED

Enrique T. Yap, M.D., D.A.B., F.I.C.S./metropolis

MASSIVELY BLEEDING gastroduodenal ulcer in the aged remains one of the standing blocks of medicine. Despite the rapid progress in surgical technique, improved anesthesia and modern pre-operative and post-operative care, mortality figures are far from being ideal.

Treatment has shifted like a pendulum from surgical to medical and back to surgical again. Lately large medical centers have followed the combined medical-surgical approach as advocated by astute clinicians. These medical centers claim a significant reduction in mortality rates when these types of patient are handled by a medical-surgical team. Significant reduction has been attained in the young and middle aged groups but mortality remains high in the aged. When bleeding plays a major role in a patient's illness, then in the aged it plays even a greater role. Complications accompanying massive hemorrhage are apt to occur in the aged.

This paper is primarily concerned with a review of the mortality cases. It is hoped that evaluation of these patients will bring about renewed efforts to obtain a much lowered mortality and morbidity rates.

In a five year period cases of massively bleeding gastroduodenal ulcer were reviewed at Maumee Valley Hospital as presented in a previous paper.[13] This review revealed a mortality rate of 38.4%. There was a total of eighty-two patients. Thirty were non-massive and fifty-two were massive bleeders. Of the massive fifteen were proven gastric ulcers and thirty-seven were duodenal ulcers, a ratio of 1:2.4. Twenty-seven of the massive bleeders were operated with nine deaths, and operative mortality of 33%. The rest were treated conservatively with 11 deaths, or 44.4%.

Case No. One (Non-operative)

D.B., 63 years old, white male admitted in shock with history of hematemesis and tarry stools on the day of admission. He has been having intermittent tarry stools for the past four weeks and weight loss of twenty-five pounds. Admission B/P 64/40. Pulse 144/min., weak and thready. WBC 8,100. Hemoglobin 7.7 grams. Hematocrit 42%. Liver function—not done. BUN not done. Circulating Blood Volume: 2080cc. Whole Blood Volume. He was transfused

with twenty-two pints of blood and seemed to improve. On the fifth day he passed about 3,000cc. of bloody stools and expired.

Post mortem examination was not done.

Case No. Two (Operative)

M.L., 67 years old, white male admitted in diabetic coma which was controlled. Fifteen days after admission he developed massive hematemesis. Hemoglobin 9.1 grams. BUN 24mg.%. Circulating Blood Volume: -1420cc. Whole Blood Volume; -20cc. Plasma Blood Volume; -440cc. Red Blood cell volume. He improved with blood transfusion and a total of five pints were given with very good response. He was operated on the 15th day. A partial gastrectomy with ante-colic anastomosis was done.

The findings were peptic ulcer of the stomach and duodenum. He was doing fairly well after surgery but soon developed pulmonary atelectasis and expired on the fifth post-operative day.

Post mortem examination showed subdiaphragmatic abscess and acute purulent bronchopneumonia.

Case Summaries and Discussion

Some of the cases studied required resuscitation efforts consisting of pumping of blood into the patient to keep up with the loss. If no improvement occurred or no signs of response was evident they were operated on immediately. It is sometimes necessary to have two "cut-downs" or phlebotomies for fast reconstitution. If this procedure was required, we believed that this type of patient will not respond to conservative therapy.

One should not wait too long to decide whether patient will require surgery or not. For every hour's delay in operative treatment, mortality and morbidity increase. There is truth in what Fenesterer originally claimed that "surgical mortality increases after the 48 hour period." In the aged the danger increases three-fold.

The aged's response to bleeding is physiologically unique in that the basal resistance of the body is at a much lower level than its youthful counterpart. Numerous complications appear with worsening of degenerative processes. The patients that responded to initial therapy as exemplified by Case No. One, should be watched carefully. The effect of bleeding has changed their physiological makeup and many complications are apt to develop. Rebleeding is to be constantly watched for. It is poorly tolerated by this type of patient, if not immediately fatal.

In this review it is worthy to note that there is an associated gastritis and/or duodenitis in every case of bleeding gastroduodenal ulcer. Gentle handling of gastroduodenal structures and a more meticulous anastomosis should be performed if post-operative complications are to be avoided or minimized. In treating ulcer conservatively, extreme care should be exercised to avoid further progression of this inflammatory process or to control it by adequate means. This aids in prevention or control of further bleedings and healing of ulcer. Along with this inflammatory process in the gastroduodenal segment is an elevation of the total white cell count.

Discrepancy in statistical figures with regard to causes of death from bleeding ulcers deserves consideration. The marked contrast between our cases and Harvey's[6] stresses this point. Table 1 lists our own cases in Maumee Valley Hospital as previously presented.

TABLE 1

Causes of Death:	
A. Non-operative:	
Exsanguination	7
CVA	2
Congestive Heart Failure	1
Undetermined	1
Total	11
B. Operative:	
Cardiac arrest	2
Atelectasis	4
Peritonitis	1
Post-Op Hemorrhage	1
Pulmonary edema	1
Total	9

TABLE 2

Harvey's 465 cases:[6]

A. Non-operative deaths:	
Exsanguination	3
Coronary occlusion	3
B. Operative deaths:	
Congestive Heart Failure	2
CVA	2
Coronary occlusion	1
Pulmonary embolism	3

Harvey's series predominantly deals with associated ailments which are already present and are aggravated or progressed because of bleeding or operation. There were only three that were attributed to exsanguination. Table 2 presents an entirely different date. Conservative regime carried a large toll. Exsanguination occurred in seven out of eleven conservatively treated cases. Conservatism connotes that a good deal of caution should be practiced and adequate and competent follow-up care is available. One should have the readiness to abandon this form of management and resort to surgery when times arises. (See Table 4.)

In the operative group, as exemplified by Case No. Two, pulmonary complications still lead in the causes of death in our series. There were five pulmonary complications out of nine post-operative deaths. These complications listed under operative group are common in gastric operations. Careful pre-operative and post-operative care with competent anesthesia should lower these complications and reduce mortality. Competent and adequate nursing care is required to obtain lesser post-operative complications. This has been a problem in recent years.

There is a definite diminution of pulmonary ventilation as measured by vital capacity and tidal volume after abdominal operations especially so with upper abdominal procedures. This has been experimentally proven by several authors.[2,3]

Seybold[11] emphasized the disturbance in the physiologic mechanism of respirations contributes to development of post-operative pulmonary complications. He mentions three factors directly related to the production of this type of complication-pulmonary ventilation, bronchial function, and cough. We agree that any deviation from the physiologic mechanism of these factors leads to the development of pulmonary pathologic processes. Since this change is most apt to occur after surgery, extra care should be exercised to prevent its occurrence. Some well-known measures that aid to prevent pulmonary complications can not be over-emphasized. Among them are coughing, deep breathing exercises, carbon dioxide[10] inhalations, early ambulation, and endotracheal suction. Some authors[10] recommend the use of intermittent positive pressure breathing machines especially in older individuals to prevent or minimize the production of pulmonary complications. This machine assists the patient's respiration; thereby increasing pulmonary expansion and toilet. It provides adequate ventilation and facilitates expectoration of bronchial secretions. Greene and Berkowitz[7,5] recommend induced coughs, detection of susceptible patients and institution of proper measures to prevent or lower pulmonary complications. (See Table 3.) They list the following as the more common factors responsible for the development of pulmonary complications:

1. Susceptible patients.
2. Anesthesia.
3. Position of patient—Trendelenburg and flexed position.
4. Depression of cough reflexed by heavy pre-medications, basal anesthesia, and narcotics.
5. Inherent factors—emphysema, obesity, abdominal distention, etc.

Knowledge of fluids and electrolytes, and circulating blood volume studies[4] have

TABLE 3

Results of induced coughs: (Greene and Berkowitz)[5]

SUBTOTAL GASTRECTOMY	
No. of cases	215
Complications	37
No. of cases with induced cough	223
Complications	1
BILIARY PROCEDURES	
No. of cases	413
Complications	42
No. of cases with induced cough	359
Complications	0

TABLE 4

Authors	Pulmonary Complications	Post-op Hemorrhage	Peritonitis or Sepsis	Cardiac	Cerebral	Misc.	Total Deaths	Mortality Rate
Hollman(24)[8]	2	3					5	21%
Welch(186)[12]	11	5	5			4	25	13%
Harvey(72)[6]	3			3	2		8	11%
Marshall(52)[9]	4	1	2	—	1		8	15%
Simeone(50)[1]		7	5				12	24%
Present Series(27)	5	1	1	2			9	33%

developed at a rapid phase in the last few years; consequently pulmonary edema or its equivalent seldom occur. If it does occur, it is usually adequately and intelligently corrected. (See Table 4.)

Hoerr[7] did not find any distinct advantage of prophylactic antibiotic therapy in the prevention of pulmonary complications. However, antibiotics do have a definite role after such complications have developed.

Peritonitis and post-operative hemorrhage will probably be encountered in a small number of cases regardless of precautions taken as reported in literature [8, 9, 12]. The rest are attributed to pre-existing disease (See Table 5).

Conclusions

The following conclusions are derived from this study:

A. Gastritis and/or duodenitis are commonly associated with bleeding gastroduodenal ulcers. Increase in total white blood cell count is not infrequent.

B. Emergency Circulating Blood volume is valuable. Adequacy of blood replacements are measured according to this data. This prevents overtransfusion as well as undertransfusion. Hemoglobin and hematocrit may be misleading because of hemoconcentration but helpful relative to follow-ups.

C. If medical conservative therapy is instituted, extra care is exercised and patients should be watched very carefully. If rebleeding occurs, immediate transfusion and surgery are mandatory.

D. Lowered mortality may be accomplished in patients with massively bleeding peptic ulcer by:

1. Investigation for associated ailments and careful selection of patients for surgery.
2. Early transfusion and emergency surgery performed if response is unsatisfactory to preliminary therapy.
3. Careful pre-operative and post-operative care with wise choice of anesthesia.

E. Hemorrhage is a serious complication in the aged and is attended by a higher complication and mortality.

Summary

Review of mortality from massive bleeding gastroduodenal ulcers was made at Maumee Valley Hospital, in Toledo, Ohio.

The operative mortality is 33%; non-

TABLE 5

Causes of Non-operative deaths:

Author	Exsanguination	Cardiac	Cerebral	Uremia	Misc.	Total	Mortality Rate
Hollman(66)[8]	8					8	12%
Harvey(394)[6]	3	3				6	2%
Simeone(246)[1]	92	7		2	5	106	43%
Present Series(25)	7	1	2		1	11	44.4%

operative mortality is 44.4%. The overall mortality in this review is 38.4%. Exsanguination is the leading cause of death in the non-operative group. Pulmonary complications supersede the rest of the causes of death in the operative mortality.

Conclusions derived from this study emphasize (1) important considerations to lower post-operative complications; (2) early surgery without delay when indications arises.

References

1. Atik, M., and Simeone, F. A.: Massive Gastrointestinal Bleeding. *AMA Arch. of Surg.* 69:355-365, 1954.
2. Beecher, H. K.: The Measured Effect of Laparotomy on the Respiration. *Journal of Clin. Invest.* 12:639-650, 1933.
3. Churchill, E. D., and McNeil, D.: Reduction of Vital Capacity Following Operation. *Surg. Gyn. & Obst.* 44:483-488, 1927.
4. Crehan, Jos. P.: The Value of Blood Volume Determination in Poor Risk Patients. *Surgical Clinics of N. A.*, 605-608, June, 1954.
5. Greene, B. A., and Burkowitz, S.: An Anesthesiologist's Program for Prevention of Post-Operative Pulmonary Complications. *New York J. of Med.* 52:1871-1878, 1952.
6. Harvey, Harold D.: Acute Massive Hemorrhage and Acute Perforation in Peptic Ulcer. *Surgical Clinics of N. A.*, 369-381, April, 1955.
7. Hoerr, Stanley, O.: Antibiotics and the Prevention of Post-Operative Pulmonary Complications. *Ohio State Med. J.* 45:225-228, 1949.
8. Holman, Cranston, W.: Severe Hemorrhage in Gastric and Duodenal Ulcer. *Anal. of Surgery*, 40:150-160, 1940.
9. Marshall, Samuel, and Reinstine, Harry, Jr.: An Analysis of Mortality Following Gastric Surgery. *Surgical Clinics of N. A.*, 637-652, June, 1957.
10. Noehren, Theodore H., et al.: Intermittent Positive Pressure Breathing Machine (IPPB/I) For Prevention of Post-Operative Pulmonary Complications. *Surgery.* 43:658-665, 1958.
11. Seybold, Wm. D.: Physiologic Disturbance Underlying the Development of Early Post-Operative Atelectasis after Lobectomy. *Surgical Clinics of N. A.*, 871-888, August, 1948.
12. Welch, Claude, and Allen, A.: Surgical Management of Massive Acute Upper Gastro-Intestinal Hemorrhage. *N.E.J. of Med.* 252:921-928, 1955.
13. Yap, E. T., and Hotz, R.: Bleeding Peptic Ulcer, *J.I.C.S.*, May, 1965.

Letter to the Editor:

ROUTINE BLOOD GLUCOSE FOR NEWBORN INFANTS

I believe that the suggestion that "hospitals consider the institution of routine blood glucose determinations in their newborn nurseries" is misleading. I disagree that transient *symptomatic* neonatal hypoglycemia can be calculated to be 500 to 1000 times greater than uncovering one case of PKU in normal full term infants. In premature infants the incidence *is* higher. I also do not believe that there is incontrovertible evidence that 20 percent of infants treated for transient hypoglycemia show subsequent mental retardation. I would agree that blood sugar determination be performed on the neonate when there is reasonable possibility of hypoglycemia, viz, maternal diabetes, toxemia of pregnancy, drug intoxication (transmitted from the mother), respiratory distress syndrome and when there is a family history of an inborn error of metabolism. For these reasons, it is my opinion that neonatal blood glucose determination should be the prerogative of the obstetrician and/or pediatrician responsible for the infants care.

Ralph H. Kunstadter, M.D.
Chairman, Child Health Committee
Illinois State Medical Society

THE SATIRISTS' WAR ON MEDICINE

Edward Rosenheim, Jr./chicago

I'M VERY GRATEFUL for the generosity and the courage which this society has displayed in deliberately making itself a captive audience for the verbal carryings-on of an English teacher. I mention your courage because I think all of us who lay claim to special interests or vocational preoccupations have been somewhat bullied and terrorized these days by talk of the "problem of communication." This talk—wherever it comes from, and whether it's pretentiously formulated as the matter of there being "two cultures" or whether it takes shape in the ridiculous image of the Ivory Tower or the Intellectually Brilliant but Spiritually Impoverished Man of Science—adds up to the same, rather dangerous proposition. The proposition is that once a man assumes a professional or vocational identity, once, that is, he commits himself to a single intellectual pursuit, however broadly defined, he becomes a "specialist." And so contagious are our habits of speech that an adjective is almost inevitably soon tacked-on, and he becomes a "narrow specialist." From this labelling, it is only a short jump to the assumption that you, as physicians, are indifferent, if not hostile, to the activities of the English professor (and to much else besides); while I, as a sequestered denizen of the Ivory Tower, am deaf to the thundering resonances of the scientific and social revolution which is going on all about me.

As I am neither a philosopher nor an expert in adult education, I'll conform to this view of the specialist to the extent of refusing to discuss such questions as whether a man has a solemn duty to "broaden himself" or whether a man who is intensely and profitably pursuing questions of great importance to himself and his colleagues should be harried by the requirement that he "communicate" with those who share neither his expertise nor his passion. I would like to suggest, however, that "communication" and mutual understanding can and should occur most happily at certain points, in both your profession and mine, when we face problems of common interest. In other words, I can probably, on invitation, explain to you what I'm "up to" professionally, and you can return the compliment; and each of us may, if you will, be broadened and enlightened by the exchange. But I am uneasy about "mutual understanding" when it is pursued as a solemn duty. It seems to me that such understanding comes about more naturally and importantly as a product of our approach to matters of common concern. "Communication," I think, best takes place when we are addressing the same questions—in those areas where what I discover may not only be mildly interesting but plainly relevant to your professional concerns or in which you seek to illuminate questions that are clearly on my mind.

I'd like briefly to elaborate on what I've just been trying to say by offering an example—an example that, initially at least, may strike you as pretty "far out." Because I'd like to take a set of questions that concern me almost entirely as a professional student of literature, of the humanities, and try to suggest that they may lead to questions which concern the

Professor of English, University of Chicago.

past, the present, and perhaps the future of your own profession.

It happens that for a number of years I've been very much interested in that kind of writing which is loosely called "satire." While I've been particularly occupied with the satires of a certain period—the eighteenth century—inevitably I've become curious about questions of satire in general. Let me say at the outset that there is wide disagreement among students of the subject as to how satire may be defined, and that even the single, very broad statement I'm about to make would probably be savagely challenged by certain of my colleagues. But among most of us there is agreement that satire involves some sort of "attack," some attempt at exposure or criticism or derision. The attack is of many kinds and takes many literary—and other artistic—forms. It can, indeed, be carried out in the visual arts and even perhaps in music. But I think it can invariably be said of the satirist that he pursues the object of his attention in a spirit that is somehow hostile—whether faintly or furiously, whether briefly or permanently.

The Uses of Satire

If, therefore, satire is an artistic instrument of attack, I think you can understand some of the uses to which it can be put by students of many kinds—not least the historians and other kinds of social scientists. There are very few really interesting men or ideas or institutions which are not, to some extent, controversial, and, while the discourse of controversy takes many forms, one of the most colorful of these is certainly satire. Or again, the history of a man or idea or institution is likely to be very incomplete unless we take into account the attitudes and responses which it produced in relevant areas—the magnitude, nature, and duration of its "impact" or (in the vocabulary of contemporary publicists) its "image." And such an image is often both reflected in and produced by the satirist—as the political cartoonist imposes upon us the caricature of a Goldwater or a Lyndon B. Johnson, that caricature, in turn, reflecting our own observations of and reactions to these men.

Satire—Against and By

What I have been saying certainly applies to the task of considering the history and present status of any profession. I am going to limit myself to the satire directed against the medical profession, but I assure you that, in comparison with such other professions as the law or teaching or even certain chapters in the history of the clergy, the physician has received relatively benign treatment from the satirist. Nonetheless, to anyone interested in the history of the medical profession—as to anyone interested in the present image of the profession—satire against medicine and physicians offers some arresting suggestions as to the way in which the non-professional world has traditionally viewed your calling.

I should say, first of all, however, that the satiric dimension to the history of medicine is by no means confined to attacks *upon* the profession, for satire is a tool which potentially lends itself to any side of a controversy. Thus we could explore in considerable detail (although we lack time to do so) the satire employed *by* physicians and others against those who are, in some sense, the "enemies" of the profession. I suspect that, for example, even the most benevolent of your number have occasional moments of resentment against foolish or ungrateful patients — perhaps even fleeting twinges of indignation against patients as a whole—and it would not surprise me to learn that the catalogue of affronts and outrages I occasionally hear from my medical friends sometimes takes satiric form in your journals. It is therefore reasonable enough that the stupid, hysterical, or unappreciative patient appears prominently in satiric and other literature —the most common type of such patient perhaps being the hypochondriac. There is a kind of timeless, readily recognized ring of authenticity, for instance, in Samuel Butler's 17th-century account of the "Medicine-Taker," who "is no sooner well, but any Story or Lye of a new famous Doctor,

or a strange Cure puts him into a Relapse, and he falls sick of a Medicine instead of a Disease, and catches Physic, like him that fell into a Looseness at the Sight of a Purge."

Or again, there are assaults, many by physicians, against those who abuse and discredit the profession, assaults designed, in many instances, to distinguish the authentic from the fraudulent medical practitioner. Among these are the out-and-out quacks, of course; like charlatans of various kinds, your medical fraud presents rich possibilities for comedy and intrigue and is, accordingly, a stock figure in the fiction and drama of many literatures. Sir Thomas Overbury, in the days of James I, assailed the "Quacksalver" in these terms: "All the diseases ever sinne brought upon man, doth he pretend to be Curer of; when the truth is, his maine cunning is Corne-cutting." You will recognize the immemorial aspects of the portrait: the quack's lying pretensions are limitless; his actual accomplishments are ludicrously trifling. (For "corn-cutting," present-day physicians are likely to substitute bone-snapping, massage, or faith-healing.)

Satire for "House-Cleaning"

There are, moreover, many satiric efforts on the part of physicians to expose abuses displayed by their nominally legitimate brethren. In the literary period which most interests me, some of the most pointed criticism of the medical profession and its adjuncts is produced by men who were themselves distinguished physicians: the amiable Dr. Samuel Garth, whose *Dispensary* was a lusty weapon in an intraprofessional quarrel of the late 17th century; the remarkable Dr. John Arbuthnot, probably best known as the creator of John Bull and collaborator of Pope, Swift, Gay, and others, who was nonetheless Queen Anne's physician and a wide-ranging scientist whose satiric pen sometimes assailed those fellow-scientists who failed to meet his own standards; the novelist Smollett and the man-of-all-letters Oliver Goldsmith, both of whom, as physicians, attacked abuses within and against the profession. For these men of medicine—as for the humane, honorable professional man of any age or calling—pretentiousness, vanity, and ineptitude represented the corruption of their vocation and invited the kind of "house-cleaning" instinct which is not, perhaps, unknown to you.

But our present concern is with the picture, true or false, which the satirist paints of your profession as a whole—with the image, that is, not of the mavericks or impostors who tend to disgrace the profession, but of the "typical" physician, at least as the critics of the profession wish him to be seen. And what is, I believe, most surprising about this picture is how very little it changes over the centuries, how regularly and uniformly the same suspicions and prejudices and half-truths (and perhaps occasional truths) emerge in the hostile caricature of the medical practitioner.

Chaucer's Doctour . . .

Consider, if you will, Chaucer's account of his "Doctour of Phisik," presented almost 600 years ago in the General Prologue to the *Canterbury Tales*. In modern English, the description of this man is approximately as follows:

In all the world there was no one like him for talking of medicine and surgery. For he was trained in astronomy. By natural magic, he closely controlled his patient through the astrologically important hours. He knew well how to reckon the propitious placing of [talismanic] images for his patient. He knew the cause of every malady, whether of hot or cold or moist or dry, and where they engendered and of what humour. He was a true, perfect practitioner. When he had determined the cause and root of the disease, he immediately prescribed the remedy. He had his apothecaries constantly ready to send him drugs and syrups, for each of them worked for the profit of the other and were old friends. This doctor knew well old Aesculapius and Dioscorides, and also Rufus, Hippocrates, Hali and Galen, Serapion, Rhazes, Avicenna, Averroes, Damascenus and Constantine, Bernard, Gatesden, and Gilbertine. His diet was measured—not too much of anything, but the little he ate, nourishing and digestible. He devoted but little study to the Bible. He was dressed in red and blue cloth lined with taffeta and with silk; and yet he

was no spendthrift. The money he made during a plague he held on to. For gold, in medicine, is a healthful ingredient, and for this reason, of course, he was particularly fond of gold.

I am sure you need be no very great authority on the "public image" of your profession to recognize the familiar quality in almost every line of this ironic caricature. Here is the physician's exhaustive and exhausting "shop talk," the "narrow specialization" or obsessiveness to which I began by alluding; here are the doctor's arcane theories and practices, his self-assured assessment of causes and effects; here are his prompt prescriptions, just as promptly filled by willing, conspiratorial pharmacists; here we find his calculating concern for his own well-being, his indifference to religion, his conspicuous display of wealth in his clothing, accompanied, however, by a tenacious grip on the money earned through the sufferings of others; here, finally, is the ages-old malicious jest upon the physician's consuming love, his "Ruling Passion," the love of gold.

. . . And Arrowsmith

It is, I believe, a portrait which changes very little through the centuries. I am confident that it would be possible to discover the same charges repeated innumerable times in assaults upon physicians between Chaucer's day and our own. But to suggest its persistence, I need only point to a novel of our own country and century, Sinclair Lewis's *Arrowsmith,* which, while it exalts the mission of the lone researcher, isolated from human contact in the pursuit of scientific inquiry, does so by savagely attacking the character of the ordinary practicing physician—and, indeed, even of any researcher except the unruly maverick, whose unsociability is, for some reason, the measure of his virtue.

The physicians of Lewis's novel add very little to Chaucer's bill of particulars; they merely expand and repeat (often tediously) upon his major themes. Thus, for example, the doctors of the novel have no intellectual interests beyond their profession; their talk is only of "medicine and surgery," or else, as if to confirm their narrowness of mind, of duck-hunting, the weather, fees and professional advancement. Their skill, though respectable, is employed in as routine, self-confident a fashion as is Chaucer's physician's knowledge of the stars. They are quick and arbitrary in prescribing medicines, to be supplied by cooperative pharmacists at outrageous prices. Their learning is represented (most particularly in the chapters on medical education) as a body of inert, archaic lore, however impressive to the lay mind. They are—like the Bible-shunning medieval physician—conspicuously insensitive to spiritual values. Their coldly measured self-indulgence is thoroughly unlovable; Lewis, indeed, coins for them the phrase, "men of measured merriment." Their wealth is decorously manifested, if not in taffeta and silk, then in Brooks Brothers tailoring, splendid cars and chauffeurs. And above all, it is gold (more literally in Lewis's gold-standard days than our own) which dominates their professional lives, whose acquisition provides their ruling passion and chief motive and whose retention and multiplication is their major concern.

Now when a hostile picture is as persistent as this one of the physician, when satiric warfare is waged across the centuries with weapons that are so remarkably unchanging, one is led to ask a few questions. Even to those who are, like me, innocent of psychological or anthropological wisdom, the study of satire leads to certain questions about human attitudes and fears. How does it happen that ordinary men, generally the beneficiaries of the physician's wisdom, appear willing to concur, again and again, in charges which, assuredly, must be threadbare by now?

Weapon Against Fear

I should suggest, in the first place, that *any* intellectually trained profession creates certain kinds of uneasiness in the non-professional soul. It is probably quite true that most of us "fear the unknown," and from this it may follow that we fear even more those who know the unknown. To this must be added the proposition—true of

most professions but particularly true of medicine—that knowledge is power, power over another man's security or salvation or, in the doctor's case, health or illness, life or death. And fear, or distrust, of power strikes me as a rather basic instinct, even where, as in the case of a physician or police officer or judge, the power is vested in one who, *ex officio*, is obliged to employ it to benevolent ends.

Directly to express real fears of this kind is rarely the province of satire, but the satirist often seeks to translate fear into the language of contempt or derision. The same phenomenon is true even in common, slangy speech, which is itself often satiric in a way. Our suspicions and uneasiness in the presence of intellectual power take form in sneers at the "egghead" and "longhair." The necessary language of technical expertise is dismissed as "jargon," and the rules of orderly inquiry are viewed either as mumbo-jumbo, mystical divination, or servile, cookbook "technology."

The Great Charge of Avarice

Medicine shares with certain other professions, too, that other great charge of venality and avarice. It is hard completely to explain away the persistence of this charge, but I think one rather obvious fact may go some way toward pointing to its sources. The learned professions offer no tangible *quid pro quo;* nothing changes hands for the money that is received. One has, so to speak, little to show for his money. Even in medicine, things are not often briskly and dramatically repaired, and no professional man creates new tangible objects or moves things from one place to another or adds, indeed, to our attractiveness or well-being in any very overt way. These facts, I think, help to explain why teachers and preachers are traditionally ill-paid, and thus, among professional men, relatively immune from charges of greed; if they were to become well-paid, I am confident that accusations of avarice would soon figure prominently in the hostile image of such professions. And when a lawyer or a physician, whom we view in the first place with some fear and suspicion, manifestly thrives—not by adding to our own wealth but, as a rule, merely by *restoring* that to which we're inclined to feel we have always had a right—it is not strange that our resentment is exacerbated. And the satirist is not slow to exploit that resentment—to provide a hostile grotesque, all the more welcome for its distortion.

Research Is Vulnerable

But, of course, the physician presents his special points of vulnerability to satire. His research and diagnostic procedures often appear strange, indelicate and of little practical consequence. Thus, during the period I have studied most, Butler, Swift, Gay, and Pope were quick to exploit, for satiric purposes, the reports of experiments —some indeed foolish, others actual monuments in the history of medicine — which appeared to them nonsensical, filthy, or useless. In their writings, they gleefully assail such apparently outlandish performances as the taking of a dog's pulse, analytical techniques with human excreta, or the preposterous report of one Leeuwenhoek that he was able to behold, through finely ground lenses, a species of minute creature unobservable to the naked eye.

Again, the apparent failures of medicine, especially when preceded by various forms of solemn and mysterious diagnosis and treatment, are joyously magnified and chronicled. They form material not only for such original and devastating attacks as those we find in *Gulliver's Travels* but also—as I'm sure you're wearily aware—a shopworn, essentially unchanging body of anti-medical jokes and anecdotes. And, closely related to these traditional strictures are, of course, the allegations of cold inhumanity—of the kind we find implicit even in Chaucer's unlovable physician—which are repeated throughout the satiric assaults upon a profession which is, by definition, nothing if it is not humane.

These, then, are some of the bare outlines of a tradition of satire against medicine which, throughout the history of our own and other literatures, makes recurrent

if somewhat sporadic appearances. I say "sporadic" because students of satire soon become aware that there are historic periods in which satire of certain kinds is voluminous and robust, others in which it seems to languish. And when an institution which has previously drawn powerful satiric fire no longer seems to attract the satirist's wrath, we are naturally curious about the reasons.

Immunity from Attack?

To be candid, it appears that in recent years your profession has enjoyed comparative immunity from satiric attack. (I have, as you note, had to go back over forty years for a substantial specimen that suits my thesis.) Only in those fields which represent new and highly specialized forms of research and therapy do we now find conspicuous exceptions to this immunity. In such areas—and notably in the area of psychoanalysis—the satirist continues to have a field day. And it is interesting to note that here his wit and rancor proceed on much the same grounds as those of the satirists who assailed the great medical innovations of the Enlightenment, those developments which are fundamental in this history of anatomy, surgery, and medicine. It is alleged of these new specialties today, as it was of the "projectors" of the Royal Society, that they are given to their own unintelligible or inane jargon; they are exploring fields which have never before been respectably associated with "science" or exact knowledge; their labors are wild, unprofitable, often indecent; their results are controversial or cannot, indeed, be checked by any conventional means. Here, as it often does, satire seeks out those aspects of the scene which seem most novel and alien, thus reflecting our own uneasiness and distrust.

But to the great, respectable main body of the medical army, the satirist today pays scant attention. And, as always, although the reasons for the rise and fall of particular sorts of satire are fascinating to ponder, they are almost impossible to assess with real confidence. Is the absence of satire against physicians in our own time the result of a new, more friendly public "image"? Have we, at last, unseated Chaucer's physician and enthroned Doctors Gillespie and Kildare? If so, does this mean that the satirist's art has come off second-best to the artifice of the TV script-writer, or the public relations expert? Or does it point to a related possibility—that this is not a satiric age, that we are essentially so docile or uncritical that we neither attempt nor enjoy satire? (I hardly think this last speculation is true, for in other kinds of polemical communication we can certainly become critical, and indeed bad-tempered. And if medicine is today relatively unscathed, certainly such professions as my own are not; for within the past decade there have been literally scores of so-called "academic novels," the vast majority devoted to unabashed exposure of the moral, political, and intellectual infirmities of college professors and their world.)

Communication Banishes Satire

I am inclined to offer a somewhat more cheerful explanation, and I do so not only because I am your guest. Satire is a fascinating art, a great and useful art in many instances. Yet, I believe that it tends to thrive most in an arena of suspicion and uneasiness, of unexamined anger, of partisan commitment—and it becomes glorious largely to the extent to which it creates a memorable artistic fabric from such inglorious motives and circumstances. Thus some of the greatest satire of the Restoration and early 18th century in England is directed against science and arose from a failure to understand the nature of scientific achievement, from a confusion between what was idle and unlovely with what was profitable and permanent, from a suspicion of the power of demonstrable fact to invade the precincts of revealed truth. In effect, brilliant satire was constructed by gifted men of letters who would not or could not understand developments on an intellectual front which appeared remote from their own.

In our own day, I believe that while the

layman's mind may remain notoriously untrained or, if you will, "unscientific," it is not closed or ineducable or incurious. In our educational system, our books, and particularly our mass media there is much that is silly and distorted; but there is also much to encourage curiosity and respect and understanding toward all fields of intellectual endeavor. We professionals are in effect—and this brings me back to where I began—actually "communicating" more successfully than we ever have before, communicating not only in the tight coteries of a specially educated elite but throughout the whole of literate society. It is a communication which is not, for the most part, the result of self-conscious effort by the professional but of an inquiring, wide-ranging habit of mind which, if anything can, marks the "educated" man in a democratic society. If, in the presence of these habits of mind, the satiric attack on medicine is ever launched anew, it must proceed on firmer ground than the tired assortment of half-truths and hostile clichés which sustained it for so long in the past.

A Warning

I say, "if it is launched anew," and in these words I suggest a parting note of good-natured warning. I have said little about the truth of the satirist's strictures, about the authentic vulnerability of his victims. But if the satirist exploits the malice or narrow-mindedness of his audience, he often, at the same time, points to genuine moral infirmities in his enemies. Satire is an artistic weapon of warfare, of controversy, and in any controversy we must be alert not only to what is false and irrational but also to what is just and accurate.

There are indeed scores on which the members of all professions tend recurrently to be vulnerable. Our goals may be lofty, our achievements impeccable—but perhaps for this very reason, we have our moments of complacency, self-absorption, and vanity, precisely the qualities that yield most readily to the satirist's lash. Today's world is largely hospitable to the achievements of experts of many kinds, yet it is a hospitality which cannot be abused. Exposed, as most professions are even today, to the vestiges of misunderstanding and fear, it remains our duty to understand and seek to be understood, to remain alert to basic human responsibilities, and to remember that, although we take our work with utmost seriousness, it will not do to take *ourselves* more seriously than our fellow-men. For if we do, the satirist, with his massive artistic arsenal, stands ready to remind us, as savagely as is necessary, of our fallibility, our limitations, our obligations . . . in short, of our common humanity.

"DON'T DO SOMETHING, JUST STAND THERE"

That many reactions are incited by drugs is not surprising, for what hospital patient does not ingest at least a sleeping pill? Pressures on the physician to employ pharmaceuticals are considerable, and include, besides the indications of disease, the family, the detail man, the intern and the patient himself. To paraphrase the familiar adage, it is difficult for the modern doctor to "don't do something, just stand there." People demand the largess of modern research. That many more antibiotics, diuretics, antihypertensive agents and the like are destined to appear seems certain. The perils of therapy are not likely to abate in the near future unless our colleagues are able to shape safer molecules. *Archives of Environmental Health, August 1965.*

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

A 50-year-old white male entered the hospital complaining of slight swelling of the face and eyelids, worse in the morning but subsiding during the day. He has smoked two packs of cigarettes daily for the past 30 years.

Physical examination revealed swelling of the periorbital tissues, face and neck, with obvious neck vein distension. No dilated veins were present on the chest wall. A PA view of the chest showed slight widening of the right superior mediastinal shadow. An esophagram was done.

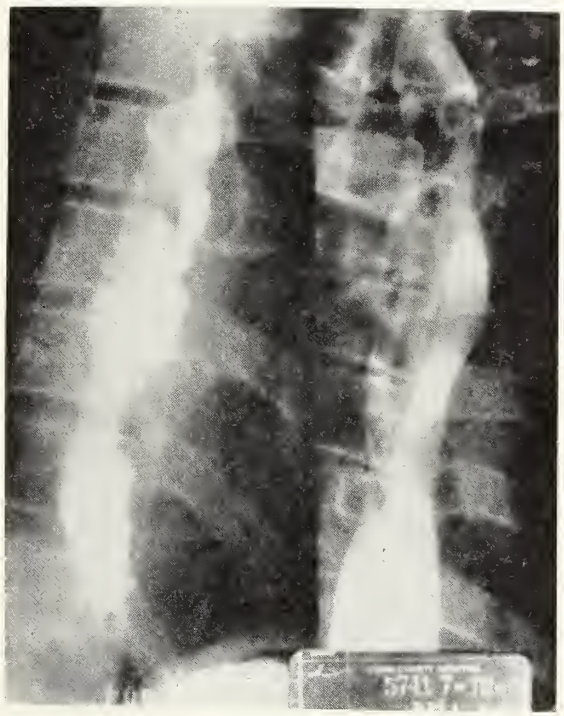


Figure 1

What is your diagnosis?

1) Carcinoma of the esophagus
2) Varices of the upper 1/3 of the esophagus
3) Peptic esophagitis

(answer on next page)

DIAGNOSIS AND DISCUSSION



Figure 2

Diagnosis: Varices of the upper 1/3 of the esophagus resulting from superior vena cava obstruction. Thirty cc. of sodium iothalamate (66.8%) were injected into each brachial vein simultaneously for purposes of visualizing the superior vena caval obstruction. Four films per second over an eight-second interval were taken. We note complete obstruction of the distal end of the superior vena cava. The upper one-third varices resulted from dilated mediastinal collateral circulation which causes worm-like pressure defects on the mucosal surface of the esophagus. The blocked superior vena cava is bypassed by shunting the venous blood into the hemiazygous system (vessel paralleling the left dorsal spine border), which then empties into the azygous system (vessel medial to the hemiazygous crossing the dorsal spine), and finally returns the blood to the right atrium.

Reference

Otto, D. L. and Kurtzman, R. S.: Esophageal Varices in Superior Vena Cava Obstruction. *Amer. J. Roentgen.* 92: 1000-1012. November 1964

ENDOBRONCHIAL LIPOMA

REPORT OF A CASE AND REVIEW OF THE LITERATURE

Victor R. Jablokow, M.D., Myron E. Rubnitz, M.D.**/hines*

LIPOMA DEVELOPING in any part of the bronchial tree, or within the pulmonary parenchyma, is a rare occurrence. There are only 30 cases described in the literature. One more is added with this report.

Diagnosis and surgical removal of this lesion is important since, although they are completely benign, their physical presence within the bronchial tree may cause pulmonary parenchymal changes secondary to the obstruction. Also, surgical removal is curative.

These fatty tumors develop endobronchially in the submucosa and grow usually into the lumen. It is not difficult to explain the presence of fat in the bronchus, since it has been shown by Watts et al[1] that it is commonly found located in the fibrous tissue external to the cartilage plates and also in the submucosa. The fat diminishes in amount in the smaller bronchi until the cartilage disappears. Normally fat may also be present close to or around submucosal glands.

Kernan[2] in 1927 reported the first case of endobronchial lipoma. The tumor was pedunculated and was attached to the right of the bifurcation of the trachea. It was removed through the bronchoscope. In their review of the literature in 1962, Plachta and Hershey[3] found 25 cases, and they added a case. The lipoma in their case was located in the substance of the lung. The patient underwent thoracotomy because of radiological suggestion of a neoplasm. Since their review, four more cases were reported.

Karady[4] described a case of a 49 year old male in whom a right middle lobectomy was done for a lipoma, 1.5 centimeters in diameter, which partially obstructed the bronchus. Tahery et al[5] reported a case of a 63 year old male with marked destruction of the right lung. Pneumonectomy was done and a pedunculated lipoma was found

*Assistant Clinical Professor of Pathology, University of Illinois; Pathologist, VA Hospital, Hines. **Associate Professor of Pathology, Stritch School of Medicine, Loyola University; Chief, Laboratory Service, VA Hospital, Hines.

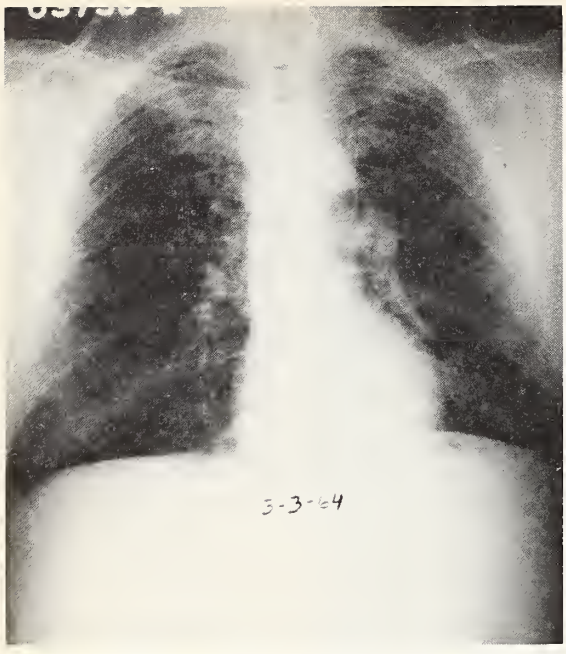


Figure 1: X-ray: AP view shows prominence of the left hilar shadow.

in the right main stem bronchus. The case reported by Horanyi[6] was the only endobronchial lipoma in his series of 2759 surgically resected lungs. It measured 1.2 x 1.0 x 0.6 centimeters and was located in the right lower lobe bronchus. Bashenov and Nikolaev[7] reported an endobronchial tumor, 1.0 centimeters in diameter, also located in the right lower lobe bronchus. The patient was a 40 year old male.

The following case, from this hospital, brings the total number of reported cases to 31.

Case Report

A 50 year old white male was admitted to the Hines Veterans Administration Hospital because of the presence of occasional epigastric and substernal discomfort for the past three years. During the medical workup by his private physician, a chest x-ray revealed a lesion in the left lung. The patient smoked 2-3 packages of cigarettes daily for the last 15 years and had smoked over a period of 37 years. He had a nocturnal cough which was productive of small amounts of white sputum which varied in consistency from thin to thick. He had a history of bronchial asthma since 1943, for which he was discharged from the Army. There was no hemoptysis or night sweats.

The physical examination on admission to the hospital revealed a well developed, obese white male in no particular distress. Blood pressure was 132/82, pulse 96. Examination of the chest revealed the respiratory excursions to be adequate and symmetrical. There was a moderate increase in the anterior-posterior diameter with dorsal kyphosis. Scattered expiratory wheezing was noted with moderate prolongation of expiration. Otherwise, the chest was clear.

Laboratory findings: The white blood cell count was 7800, with 60 neutrophils, 2 bands, 25 lymphocytes, 6 monocytes and 7 eosinophils. Urinalysis was essentially negative. Sputum culture revealed alpha hemolytic streptococci and Neisseria catarrhalis. Blood urea nitrogen was 23 mg. per cent, glucose 112 mg. per cent, creatinine 0.9 mg. per cent, thymol turbidity 3 units, total protein 7.2 gm. per cent with albumin 5.6 gm. per cent, and alkaline phosphatase 4.8 Bodansky units. Numerous sputum examinations for acid fast bacilli were negative. Esophagram and upper gastro-intestinal roentgen examinations revealed suggestive evidence of esophageal

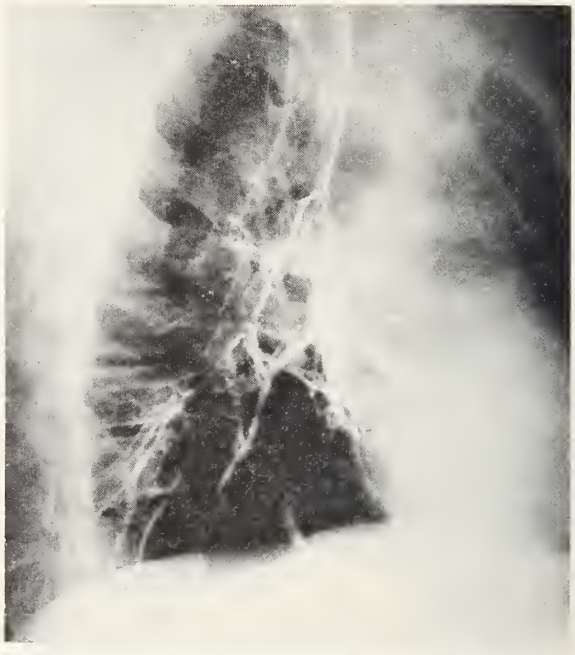


Figure 2: X-ray: Bronchogram shows obstruction of the left upper lobe bronchus.

varices and also mucosal prolapse into the base of the duodenal bulb. Pulmonary function studies were well within normal limits. The sputum was examined on three separate occasions for exfoliative cytology. Twice the smears showed no atypical cells. However, on the third examination some abnormal epithelial cells were found which were interpreted as being tumor cells.

Bronchoscopy and biopsy of the bronchial mucosa revealed squamous metaplasia of the epithelium. On another occasion at bronchoscopy a mass was seen at the orifice of the left upper lobe. Chest films, including posteroanterior (Figure 1) and lateral views, showed left upper lobe atelectasis with herniation of the right lung into the left chest. There was also a suggestion of obstruction of the left upper lobe bronchus by a hilar mass. Laminography examination of the left upper lobe revealed some linear densities radiating from the left hilar region toward the left apex. Bronchogram showed a filling defect of the left upper lobe bronchus (Figure 2).

Following review of the clinical, radiological and laboratory findings, the patient was taken to surgery where a left thoracotomy was performed and the left lung removed.

The specimen received in the Surgical Pathology Laboratory was an enlarged left lung which weighed 470 grams. On examination of the bronchial tree, a polypoid soft yellow tumor was found projecting into



Figure 3: Gross close-up of the endobronchial lesion.

the lumen of the left upper lobe bronchus. (Figure 3) The lesion measured 2 x 2 x 1 centimeters and did not extend into the wall of the bronchus or into peribronchial tissue. The mucosal surface overlying the tumor was smooth and glistening, and there was no ulceration. Cut section of the tumor revealed a homogeneous yellow glistening surface which had the characteristic appearance of a lipoma.

Multiple microsections showed the lesion to be composed primarily of adult fat tissue with only a few strands of fibrous tissue running through some areas. Occasional groups of submucosal glands were seen entrapped among the fat cells which were perfectly uniform and showed no suggestion of malignancy. The respiratory epithelium overlying this endobronchial lipoma showed

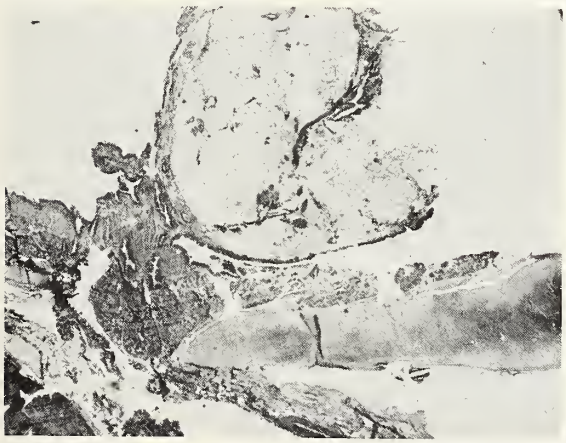


Figure 4: Low power magnification shows pedunculated lesion.

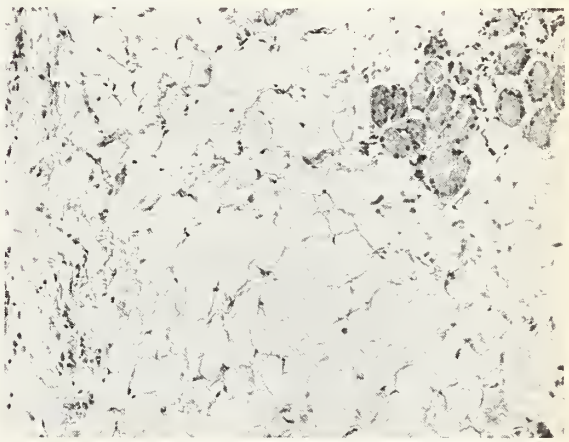


Figure 5: The tumor consists of adult fat cells. Small groups of submucosal bronchial glands are incorporated into the tumor.

evidence of squamous metaplasia, with occasional cells exhibiting some atypicality. (Figures 4 and 5) However, no malignant epithelial cells were found.

Microsections of the surrounding pulmonary parenchyma revealed moderate bronchiectasis distal to the lipoma, with chronic bronchitis and evidence of focal atelectasis and interstitial pulmonary fibrosis. Mediastinal lymph nodes were hyperplastic and showed anthracotic deposits.

Comments

Endobronchial lipomas are benign neoplasms of fat tissue developing from fat cells normally present in the bronchial wall. They cause symptoms because of their physical presence in the bronchial lumen producing obstruction. Diagnosis should be made by the use of bronchoscopy and biopsy of those lesions which are endobronchial. Lipomas within the lung parenchyma are more difficult to discover. If properly diagnosed, treatment may require only local resection or lobectomy.

Summary

A case of endobronchial lipoma is presented. The reported case brings the total number of published cases to 31. The patient is well twelve months after surgery.

References

1. Watts, C. F., Claggett, O. T., and MacDonald, J. R.: Lipoma of the bronchus: Discussion of benign neoplasms and report of a case of endobronchial lipoma. *J. Thor. Surg.*, 15, 132, 1946.
2. Kernan, J. D. Three unusual endoscopic cases. *Laryngoscope* 37:27, 1927.
3. Plachta, A., and Hershey, H. Lipoma of the lung. *Amer. Rev. Resp. Dis.* 86, 912, 1962.
4. Karady, G. Endobronchial lipoma. *Magyar Sebeszet*, 12, 305, 1959.
5. Tahery, S. A., Carberry, D. M. and Ross, Ch. A. Lipoma of the Bronchus. *New York State J. Med.* 60, 3310, 1960.
6. Horanyi, J., Horlay, B., Molnar, J. Endobronchial lipoma, *Tuberkulozis* 14:51, 1961.
7. Bashenov, V. S., Nikolaev, A. A. Lipoma of the infralobe bronchus of the right lung. *Grudn. Khir*, 4:111, 1962.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

FEBRUARY 27, 28 - MARCH 1, 2, 1966

Palmer House, Chicago

THIS CONFERENCE WILL BE OF INTEREST TO ALL PHYSICIANS. It will be presented in a manner designed to interest the generalist and specialist alike. *The program is presented by types of disease entities, not sectionalized by medical specialties.* All physicians, regardless of their field of interest, will find this program to be informative and useful.

For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 So. Michigan Ave.
Chicago, Illinois 60604

ACUTE HEMORRHAGIC PANCREATITIS: BENEFICIAL EFFECTS OF PRIMARY EXCISION OF GROSSLY NECROTIC PANCREATIC TISSUE

Lawrence G. Khedroo, M.D. and
Philip A. Casella, M.D./chicago

ACUTE HEMORRHAGIC PANCREATITIS with superimposed pancreatic necrosis, manifesting intense symptoms and signs referable to the gastrointestinal and cardiovascular systems, carries a respectable morbidity and mortality. The addition of a surgical procedure, as a diagnostic and/or therapeutic measure, can possibly add further insult to the already inflamed peritoneal cavity, the locus of a spreading or a diffuse peritonitis. Currently the definitive treatment for this disease process is conservative and supportive. Laparotomy is indicated in the presence of obstructive jaundice, lack of response to conservative treatment, signs of a spreading peritonitis, the presence of a palpable abdominal mass, or when pancreatitis has been excluded as a cause of the acute abdominal process.[1-9] Past experimental studies,[10, 11] the application of available and helpful supportive measures (blood infusions, antibiotics, gastrointestinal tube-decompression, oxygen inhalation), and the feasibility of exposing fully the pancreatic region have made it possible to selectively extend the operative procedure safely. Herein are reported the case histories of two patients in whom the indication for laparotomy was present and in whom grossly necrotic pancreatic tissue was adequately exposed and excised, patently ameliorating the postoperative recovery period and leading to full recovery.

Case Report

On July 27, 1962 a moderately well nourished, apprehensive, 39-year-old male was admitted to the surgical service complaining of epigastric pain. It had been present four days and was associated with recurrent emesis of ingested food of two days' duration, as well as two episodes of black stool passage within the previous twelve hours. The abdominal pain was nonradiating, persistent and prevented ambulation in an upright position. The inventory of symptoms by systems was negative. Past history revealed an episode of acute colitis, at which time upper abdominal and colon barium x-ray studies were reported normal-average, 1958; and a hospitalization for a compression fracture of the fifth lumbar vertebra, left parietal skull fracture and a compound fracture of the right tibia, all secondary to an automobile accident, 1958. He smoked three packages of cigarettes every day, ingested alcoholic beverages in more than moderate amounts, and had noted allergic reaction to ingested and injected penicillin.

Physical examination noted tenderness

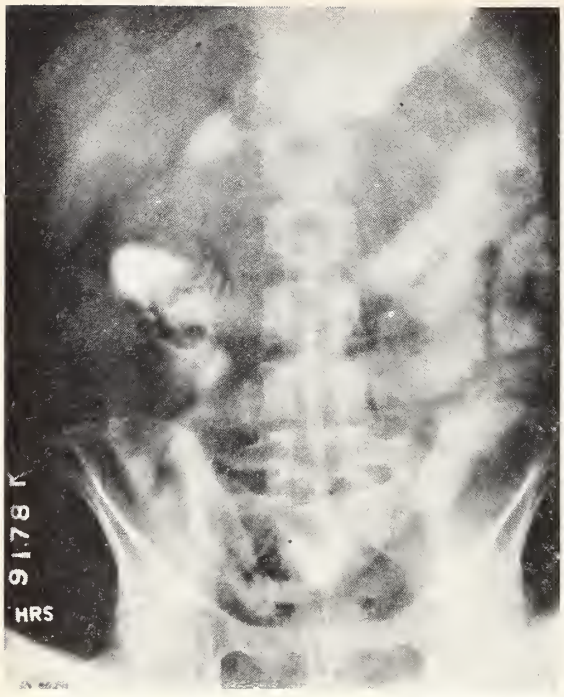


Figure 1: Ingested barium upper gastrointestinal x-ray discloses widened pyloroduodenal curve; this was considered due to a mass. At surgery an enlarged necrotic pancreas with peripancreatic fat necrosis was found.

and rigidity in the upper half of the abdomen, very light tan stool on digital rectal examination, and an oral temperature of 100°F as the pertinent/objective findings.

Laboratory studies disclosed a peripheral white blood cell count of 10,900 with 77% polymorphonuclear leukocytosis, four plus blood on gastric analysis, serum amylase value (Krautman[13]) of 146 units, and serum lipase value of 0.3 units (Cherry and Crandall[14]). An upper gastrointestinal barium x-ray (Figure 1) revealed a widening of the pyloroduodenal curve, considered to be due to a mass of extrinsic origin; a normal-average cholecystogram was noted.

The patient was treated conservatively with bed rest, sedation, intravenous electrolyte and glucose solution feedings, and gastrointestinal decompression. An improvement was noted and he was discharged from the hospital on August 4, being advised to ingest a bland diet and take anticholinergic oral medication.

On September 2 the patient was readmitted with the complaints of recurrent epigastric pain, dyspepsia and diarrhea. The physical examination was unchanged except that there was present a tender ten cm. diameter mass in the epigastric region. Forty-eight hours later the patient was taken to the surgical amphitheater and, under a general anesthesia, was laparotomized.

Surgical Findings

At surgery the gross findings revealed a markedly enlarged pancreas, putty-like and indentable to finger palpation. (Similar to indentations as are noted when digitally compressing an edematous ankle.) There was fat necrosis in the peripancreatic tissues, mesocolon and greater omentum. The transverse colon was attached to the head of the pancreas by fibrous adhesions. The gall bladder wall was moderately inflamed and the organ disclosed no palpable calculi. The cystic duct, hepatic duct and the common bile duct were normal-average. Multiple adhesions were present between the edematous greater omentum and the body of the pancreas. The epiploic foramen was opened digitally and the descending and horizontal portions of the duodenum were carefully stripped from the posterior abdominal wall exposing the posterior aspect of the head of the pancreas, the right renal vessels and the abdominal inferior vena cava. The greater omental cavity was opened, the transverse colon lifted superiorly and the body and tail of the pancreas exposed. The lesser omental cavity was opened to expose and control the structures of the portal triad. The adhesions of the transverse colon were left intact. The distal two-thirds of the pancreas was resected in three pieces with alternate sharp and blunt dissection. Pancreatic arterial rami of the splenic artery were exposed, ligated and divided. Inspection following this procedure revealed that only that portion of the pancreas to the right of the superior mesenteric artery, i.e., that closely adherent to the transverse colon, remained. A large fenestrated rubber drain was placed in the bed of the resected pancreatic tissue and led extra-abdominally through a separate incision in

the left posterior axillary line. A cholecystectomy was performed. Careful palpation of the common duct revealed no calculi. The abdomen was closed. The patient was returned to the recovery room in good condition. His recovery was smooth with supportive care and he was discharged from the hospital on the twenty-fourth postoperative day.

The pathology report stated: the specimen of tissue consisted of pultaceous grayish-tan material which measured 12x 3x2 cm.; microscopic examination revealed "ghosts of lobules which contained ghosts of acini and islets, covered in places with a capsule which was edematous and extensively infiltrated with round cells (Lymphocytes-Leukocytes), plasma cells, and some eosinophilic leukocytes; the gall bladder disclosed infiltration of the membrana propria with round cells (Lymphocytes-Leukocytes) and plasma cells." The final pathological diagnosis was "complete pancreatic necrosis; moderate cholecystitis."

During the patient's postoperative convalescence the following blood studies were performed: serum amylase,[13] fasting blood sugar,[12] serum lipase,[14] serum glutamic oxalacetic transaminase,[15] serum glutamic pyruvic transaminase[16] (Figure 2). A repeated upper gastrointestinal barium x-ray still revealed a moderate widening of the duodenal loop. A glucose tolerance test on October 17, 1962 disclosed a blood sugar level of 285 mgm.% at the end of two hours accompained by a 3+ urine sugar determination. All these test were repeated on January 3, 1963 with normal-average findings.

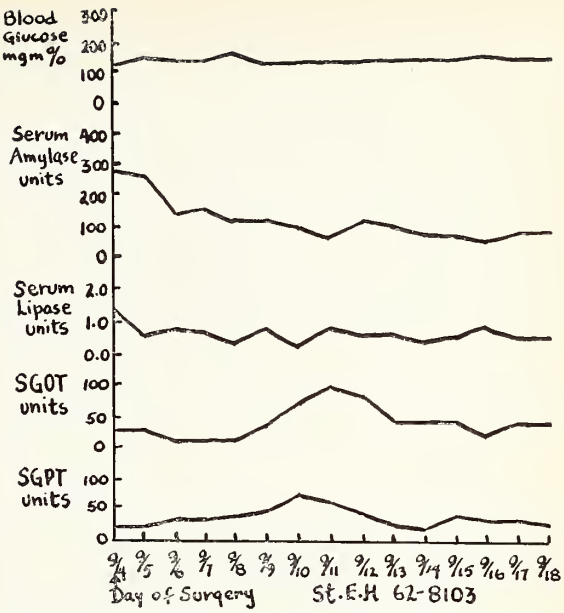


Figure 2: Peripheral blood studies during the two weeks' postoperative course disclose a stable blood glucose, a fall in serum amylase and a late postoperative rise and fall in SGOT and SGPT.

Case Report

History revealed that on December 30, 1962 a well nourished, married, 37-year-old female was admitted to the surgical service with the chief complaints of abdominal pain, sudden and sharp in onset, recurrent vomiting of ingested food and fatty dyspepsia. The inventory of symptoms by systems was negative. Past history revealed conservative treatment for rheumatic fever in her youth, left salpingo-oophorectomy for an ectopic pregnancy in 1947 and intermittent digitalis therapy for her rheumatic heart disease. No history of an episode of cardiac failure was elicited.

Physical examination noted an icteric tint of the sclerae, marked abdominal epigastric tenderness and an occasional auscultated premature cardiac contraction (every 10-15 beats).

Laboratory data disclosed a peripheral white cell count of 21,600 with 88% polymorphonuclear leukocytes, serum amylase of 170 units (Krautman[13]) and 30 mgm.% of albumin in the catheterized urine specimen. The electrocardiogram disclosed auricular fibrillation with a ventricular rate of 140 per minute. A working diagnosis of acute cholecystitis was entertained.

Surgical Findings

Surgery was performed on January 1 under a general anesthesia. Laparotomy disclosed an acutely inflamed gall bladder filled with small calculi, a dilated common duct and marked enlargement and edema of the pancreas with gross peripancreatic tissue fat necrosis. A cholecystectomy and a choledochotomy were performed. The

inability of a metallic flexible probe to enter the duodenum necessitated a duodenotomy. The latter exposure permitted the extraction of an impacted calculus from the ampulla of Vater. The duodenotomy was repaired by suture, a T-tube drainage of the common duct effected, the abdomen closed and the anesthesia terminated with the patient in a satisfactory condition. Supportive conservative therapy, consisting of gastrointestinal transnasal tube decompression, antibiotics, sedation and intravenous infusions of glucose and electrolyte solutions, was instituted.

On January 14 the patient exhibited recurrent perspiration, anorexia, septic temperature, malaise, and a firm tender globular mass in the epigastric region. A plain x-ray of the abdomen taken on January 25 (Figure 3) disclosed only a few distended loops of small intestine.

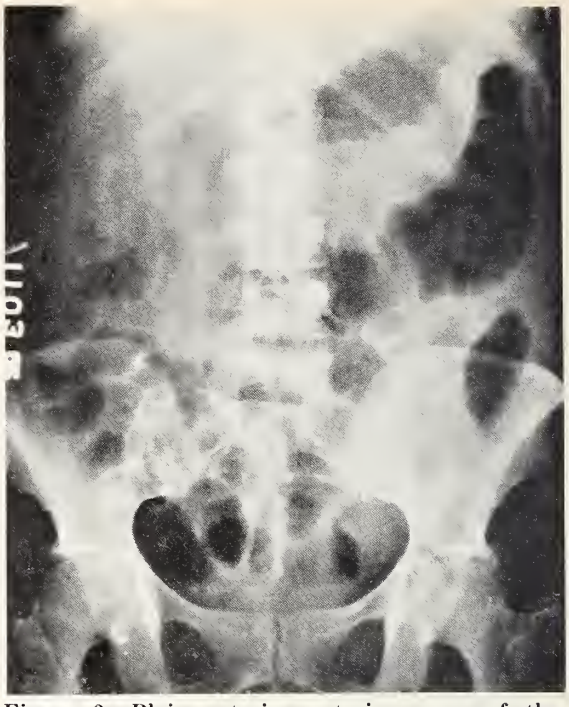


Figure 3: Plain anterior-posterior x-ray of the abdomen shows distended upper intestinal loops, with glass ground haziness in the mid epigastric region. At surgery a hemorrhagic and necrotic pancreas with peripancreatic necrosis was found.

On January 28 the patient was returned to the surgical amphitheatre and under general anesthesia, through the previous incision, a second laparotomy was performed. Upon careful division of infrahepatic adhesions there was noted marked inflammation of the pancreas head with liquefaction of peri-pancreatic serosal tissues. Division of the gastrocolic ligament revealed necrosis of the body of the pancreas; 100 c.c. of grossly purulent fluid was aspirated from the lesser omental cavity. The pancreatic tissue felt putty-like. That portion of the pancreas to the left of the superior mesenteric vessels was excised, bits of tissue being removed by finger and scoop-instrument dissection. Bleeding from pancreatic rami of the splenic vessels was not noted in this instance; it was considered that some of the pancreatic vessels were thrombosed. Two large fenestrated rubber drains were inserted in the area of excised pancreatic tissue and led out through right and left mid-axillary line transabdominal stab incisions. The abdominal incision was then closed per suture. Supportive postoperative care included that applied at the initial surgical procedure.

The pathological report stated: the tissues removed, 14x4x2 cm. in gross size, microscopically revealed outlines of pancreatic acini and islet which did not take ordinary hematoxylin-eosin staining; occasionally normal appearing acini and islets were present; the aspirated intra-abdominal fluid revealed no growth on blood agar culture media.

The patient improved but continued to run a septic temperature. On February 21, 400 c.c. of foul-smelling non-fecaloid gray-white fluid were aspirated through a left flank stab wound under local novocaine anesthesia and needle direction. Following this latter procedure her hospital course improved and she was discharged on March 10, the fiftieth postoperative day.

During her early period of hospitalization laboratory tests were performed, in particular fasting blood sugar,[12] serum amylase,[13] serum lipase,[14] serum glutamic oxalacetic transaminase,[15] and serum glutamic pyruvic transaminase[16] (Figure 4).

Recent examinations of both patients (August 15, 1964) indicated that they are carrying on a normal daily activity and an

existence without medication; however, both carefully watch any excessive fatty food intake.

Discussion

Acutely inflamed tissue that has undergone necrosis acts as a foreign body within the living organism; primarily this is due to the disruption of an adequate vascular supply. The end-products or by-products of tissue destruction, when eventually absorbed by the vascular system, can cause severe focal and systemic (toxic) reactions, non-specific fatal, and of questionable pathogenesis. The advisability of removing such tissue products from the injured body organism establishes a reasonable objective of surgical treatment. The application of preoperative and postoperative supportive treatment — to combat vascular shock, spreading sepsis, gastrointestinal distention and debilitating pain—has enabled the surgeon to extend judiciously the time and extent of surgical procedures. The posterior peritoneal (retro- or extra-peritoneal) position of the pancreas should not preclude the application of adequate and open surgical exposure to visualize the entire organ and render it amenable to drainage or excision. It is not proposed that acutely inflamed pancreatic tissue be excised, but when inspection and palpation reveal gross pancreatic necrosis, excision of such potentially destructive tissue products can be expected to assist in the subsequent reparative process. With the exclusion of a vascular shock-like state, the described surgical excision can be performed under circumstances not unlike that which apply in an acutely inflamed, necrotic appendicitis, acute necrotic cholecystitis, twisted ovarian cyst with infarction and small bowel necrosis due to superior mesenteric thrombosis.

The non-surgical treatment of acute pancreatitis relies heavily on an accurate diagnosis (that excludes necrosis and its accompanying progressive, spreading peritonitis) and on the patient's ability, with supportive therapy, to resist and repair a damaging and potentially lethal process. The surgical treatment that inspects, confirms the diagnosis and then results in the placement of drains also indicates undue confidence in the patient's recuperative powers and in the ability of a liquefying necrotic process to be drained usually against the pull of gravity, unless a sump-pump mechanism is attached to the drains.

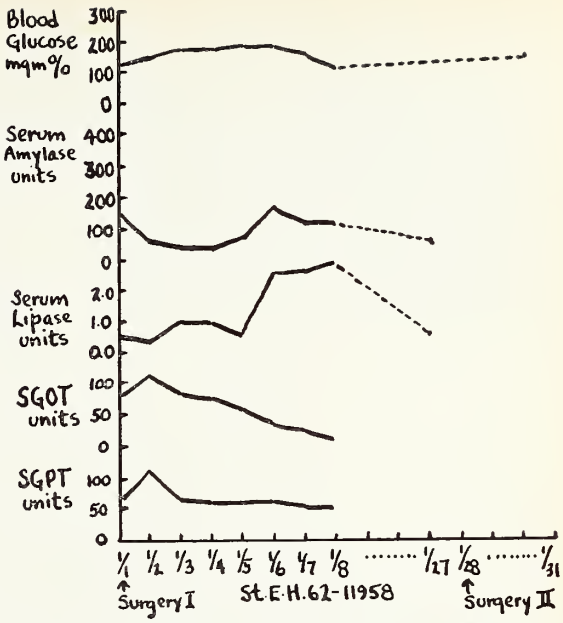


Figure 4: Peripheral blood studies at the initial surgical procedure disclose a stable blood glucose level, a marked late rise in serum lipase and a rise and early fall in SGOT and SGPT.

It was noted in these two case studies that the initial blood enzyme and chemical examinations did not mirror the severity of the disease process. The preoperative serum amylase determinations were within limits of normal-average; it can be surmised that the extensive pancreatic necrosis actually eliminated excessive formation and dispersion of large quantities of pancreatic amylase. The postoperative blood sugar determinations were also noted to be within normal-average limits, thus indicating that the remaining cephalic portion of the pancreas contained some viable islet cells and an intact blood supply.

References

1. Allen, J. G., Harkins, H. N., Moyer, C. A., and Rhoads, J. E., *Surgery: Principles and Practice*, J. P. Lippincott Co. (Philadelphia), 1957, p. 719.
2. Blackburn, G., and Lawrie, R., *Textbook of Surgery*, Chas. C Thomas (Springfield), 1958, p. 667.
3. Cole, W. H., and Zollinger, R. M., *Textbook of Surgery*, Appleton-Century-Crofts (New York), 1963, p. 700.

4. Farquharson, E. L., *Textbook of Operative Surgery*, Livingstone, Ltd. (London), 1962, p. 610.
5. Harmer, M., and Taylor, S., *Rose and Carless Manual of Surgery*, Williams and Wilkins (Baltimore), 1960, p. 1163.
6. Moseley, H. F., *Textbook of Surgery*, C. V. Mosby (St. Louis), 1952, p. 405.
7. Nardi, G. L., and Zuidema, G. D., *Surgery*, Little, Brown and Company (Boston), 1961, p. 357.
8. Oliver, L., *Basic Surgery*, Chas. C Thomas (Springfield), 1959, p. 68.
9. Warren, R., *Surgery*, W. B. Saunders (Philadelphia), 1963, p. 855.
10. Khedroo, L. G., Acute Hemorrhagic Pancreatitis, *A.M.A. Arch. Surg.* 74:220, 1957.
11. Khedroo, L. G., Casella, P. A., Portillo, A., and Cantu, W., Acute Hemorrhagic Pancreatitis, *Jnl. Int. Coll. Surg.*, 33:253, 1960.
12. Folin, Otto, and Wu, Hsien, A Simplified and Improved Method for Determination of Sugar, *Jour. Biol. Chem.* 41:367, 1920.
13. Krautman, B., Unpublished Data.
14. Cherry, Ian S., and Crandall, Lathan A., The Specificity of Pancreatic Lipase: Its Appearance in the Blood After Pancreatic Injury, *Amer. Jour. Physiol.*, 100:266, 1932.
15. Reitman, S., and Frankel, S., A Colorimetric Method for the Determination of Serum Glutamic Oxalacetic and Glutamic Pyruvic Transaminase, *Am. J. Clin. Path.*, 28: 56, 1957.
16. Wroklewski, F., and Cabaud, P., Colorimetric Measurement of Serum Glutamic Pyruvic Transaminase, *Am. J. Clin. Path.*, 27:235, 1957.

CURRENT THERAPEUTIC RESULTS IN SCHIZOPHRENIA

In this country during the period 1910-1940 the problem of chronic hospitalization of schizophrenic patients was aggravated by many factors. Large-scale immigration and the resulting social dislocation, pared hospital budgets during the Depression and rejection of schizophrenic patients by their upwardly mobile relations all worked to inhibit rehabilitation of the mentally ill. For the first twenty years of this century 44 per cent to 51 per cent to 58 per cent of first-admission schizophrenic patients remained chronically hospitalized. In the 1940's after the advent of the supposedly specific treatments of insulin, Lobotomy and finally electric shock, between 20 and 27 per cent of admissions required chronic hospitalization. After these "specific" treatments were all but discarded, both in this study and in those cited above, chronic institutionalization has declined still further to 8 to 19 per cent of first admissions. The facts that community attitudes have changed, that long hospitalization is no longer considered "good" for schizophrenia and the phenothiazines rendered schizophrenic symptoms more manageable on the ward played important parts. Perhaps more important, however, modern psychiatry may have achieved a modicum of Osler's nineteenth-century therapeutic humility and learned how to stand less in the way of natural healing processes. In the past decade, although medical "treatment" of the mentally ill has actually decreased, doctors have increasingly tried to make hospitalizations as natural and as short as possible. Less effort has been made to lock doors and to maintain security, and more notice has been taken of hospital sociology and of how to avoid transforming people into "patients." Less emphasis has been put on immutable organic causes, and more on the reversible and dynamic reasons for the patient's psychologic breakdown. Current Therapeutic Results In Schizophrenia, *New England J. of Med.* 271 (August 6) 1964, Boston.



specifically designed for estrogen replacement in the menopause...and later years

Premarin®

BRAND OF

CONJUGATED ESTROGENS (equine)

PREMARIN (conjugated estrogens—equine) is a naturally occurring, orally active, water-soluble estrogen presented as the complete equine estrogen complex. CAUTION: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period). *In the male:* Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy. AVAILABLE in 4 potencies for individualized treatment: *Tablets*—2.5 mg. (purple), 1.25 mg. (yellow), 0.625 mg. (red), 0.3 mg. (green); bottles of 100 and 1,000. 2.5 mg. tablets also available in 20's.

6605

AYERST LABORATORIES New York, N.Y. 10017 · Montreal, Canada

EDITORIALS

DEATHS FROM ASTHMA

A recent study by Richards and Patrick emphasizes that asthma is a lethal disease and that deaths from asthma have been increasing in recent years.[1]

The authors report on 24 deaths due to asthma from 1937 to 1963, most of the cases occurring in the last five years. Eighteen of the deaths were characterized by progressive dyspnea cyanosis, coma and severe respiratory acidosis. Only six deaths were sudden and unexpected. Pneumonitis was the most frequently noted pathological finding and was found in 12 cases. 21 cases had large quantities of thick mucus in the tracheobronchial tree, plugging much of the airway. Aminophylline intoxication played a role in the deaths of six children. Six cases had received steroids for long periods of time. Acute pancreatitis was noted in two of these cases and possible hypoadrenalism in one case. Excessive sedation, pulmonary hemorrhage, inadequate humidification and cardiac failure were other factors in the deaths of these cases.

Logan, commenting on this paper, mentions the ominous finding of the absence of wheezing in children who have status asthmaticus.[2] Often these children have minimal or absent breath sounds in one or both lungs. These cases usually will not respond to epinephrine or theophylline because the bronchial tree is plugged with thick secretions. Such cases often have very rapid respiratory rates and are quite dyspneic and need immediate hospitalization.

X-rays of patients with this condition often fail to show much evidence of atelectasis or obstructive emphysema. High concentrations of oxygen and water vapor and expectorants to liquefy the thick bronchial secretions should be started immediately in patients with this condition.

Harvey Kravitz, M.D.

References

1. Richards, W. and Patrick, J. R.: Deaths from Asthma in Children. *Am. J. Dis. Children* 110:4, 1965.
2. Logan, G. B.: Asthma as a Lethal Disease (Editorial) *Am. J. Dis. Children* 110:1, 1965.

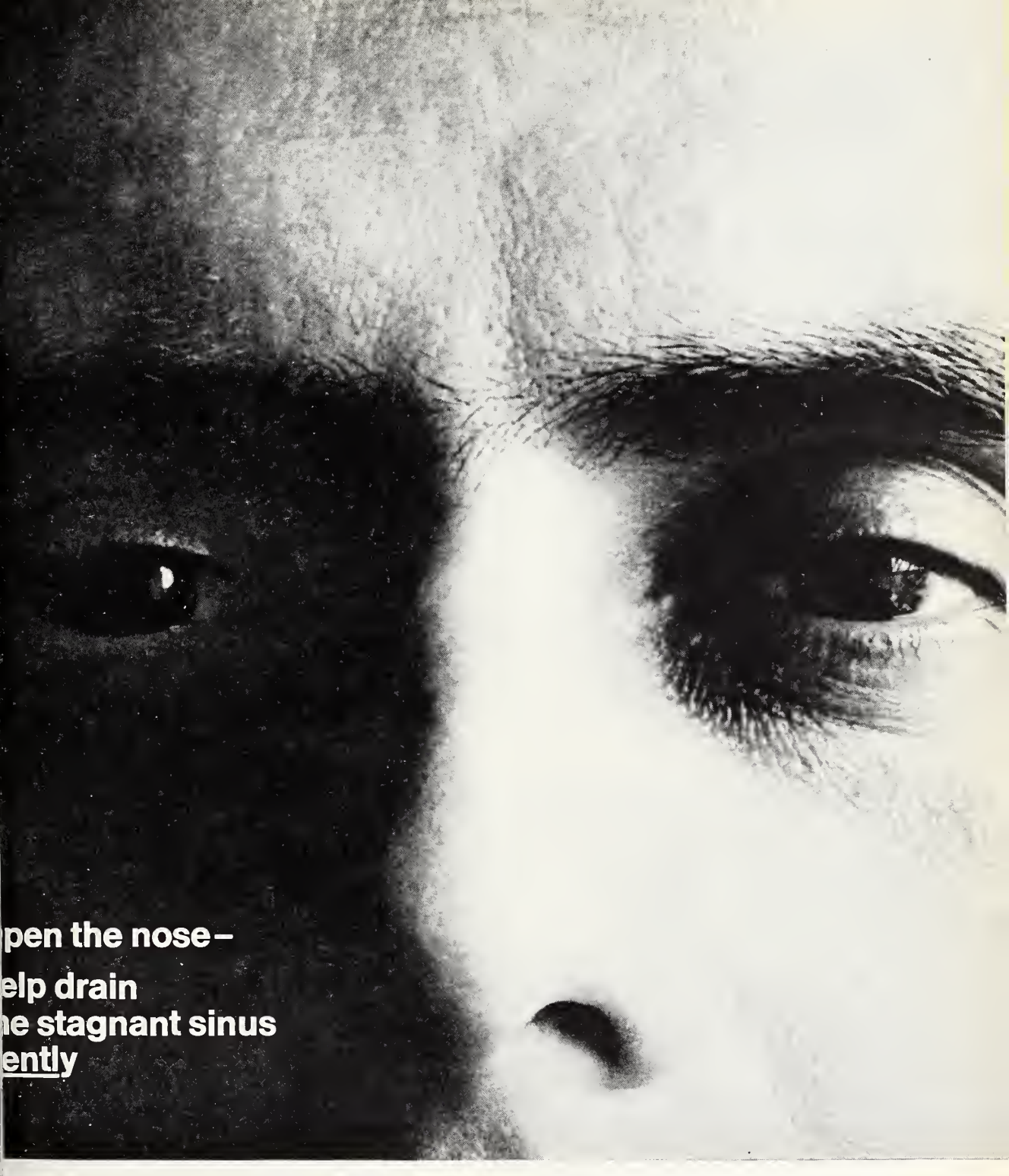
REFERRAL SERVICES FOR DRAFT REJECTEES

In recent weeks, the Department of Governmental Medical Services, American Medical Association, received several requests from state medical associations for information concerning a Federal program for counselling and referral services for Armed Forces medical rejectees. Since this program is expected to become nationwide shortly, we believe that other states may be interested in this background information.

The impetus for this program comes from a report from a task force established by President Kennedy in September 1963, composed of the Secretaries of Labor, Defense, Health, Education and Welfare, and the Director of the Selective Service System. The report, released January 4, 1964, was entitled "One Third of a Nation, A Report on Young Men Found Unqualified for Military Service," and claimed, among other findings, that about half the rejectees failed for medical reasons, and that many failing the medical examination need medical attention but are not so advised; few are now receiving treatment.

The inadequacies of this report were examined in a critique by the Division of Environmental Medicine and Medical Services, published in the *Journal of the A.M.A.*, June 29, 1964. Reprints are available on request.

The original intent was to actually induct these young men and then correct their physical and mental defects through treat-



-Synephrine is a standard among
ical vasoconstrictors. It is unsurpassed
reducing nasal turgescence in colds;
a most valuable aid in preventing
treating sinusitis.

-Synephrine stops the boggy feeling of
ds at once—works against factors that
uce sinusitis. With Neo-Synephrine
e drops, spray or jelly, turbinates shrink
ontact, obstructed ostia open and
nage is re-established.

In sinusitis, Neo-Synephrine helps to promote drainage and hasten recovery.* Used promptly, it helps clear the stagnant sinus and lessen the chances of chronicity.

Neo-Synephrine HCl is available in:
⅛% solution for infants
¼% solution for children and adults
¼% pediatric nasal spray for children
½% solution for adults
½% nasal spray for adults
½% jelly for children and adults
1% solution for adults (resistant cases)

*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

In colds and sinusitis

Neo-Synephrine® HCl

(brand of phenylephrine hydrochloride)

solutions/sprays/jelly

ment under Army auspices. This part of the program was postponed, pending further study.

The program that is now in operation is limited strictly to counselling and referral services. It is supported during the current fiscal year by a $5 million supplemental appropriation authorized last fall, according to James D. Wharton, M.D., Chief, Public Health Administration Branch, Division of Community Health Services, U. S. Public Health Service.

"HEW will provide grants to state agencies designated by the governor to provide counselling and referral service only, to the draftee who is rejected because of physical or mental disability, whenever the draftee is not under medical care and when he has some condition which requires treatment. If he has a family physician, he would be referred back to him. All of this is on a voluntary basis on the part of the draftee. The program would not provide for any additional resources for medical care, as the grant is only for counselling and referral. If the draftee has no family physician and is unable to pay for a private physician, he would be referred to a welfare or other designated relief agency, as would any other individual in the community who is indigent and requires medical care."

The first four grants under this program have been announced: to Illinois, New Mexico, Pennsylvania and Texas.

No formal AMA policy has been adopted concerning this specific program, although it will be considered at the next meeting of the Association's Committee on Federal Medical Services. Since it was initiated without benefit of new legislation, no opportunity was presented for thorough discussion of its implications.

At present, it does not include actual treatment of rejectees at Federal expense. However, it is obviously a matter of concern to the medical profession, in that it provides Federal grants to the states for evaluation of medical records and health counselling and referral for some 70,000 young men annually, solely on the basis of their having been rejected for military service.

Bryan C. T. Fenton, M.D., Director
Department of Governmental Medical Services, American Medical Association

A DISCUSSION OF TWO DIFFERENT DRUGS

Allopurinol represents another advance in our knowledge of gout. Urate in the blood comes from xanthines. Hypoxanthine is oxydized to xanthine and this in turn to uric acid by the enzyme xanthine oxydase. Allopurinol inhibits this last stage in which the xanthines are converted to uric acid. There is a reduction of serum and urine levels of uric acid and a concomitant increase in the precursors of uric acid. In this respect allopurinol offsets the action of an enzyme the disease produces.

Forty patients with primary gout were followed for three to 30 months at Duke Hospital after receiving therapeutic doses of allopurinol. The distress from the acute attacks is not changed for three to six months but in time the tophi disappear and the serum urate levels drop to normal.

The drug is well tolerated and the concomitant administration with uricosuric agents hastens the decline of serum urate levels.

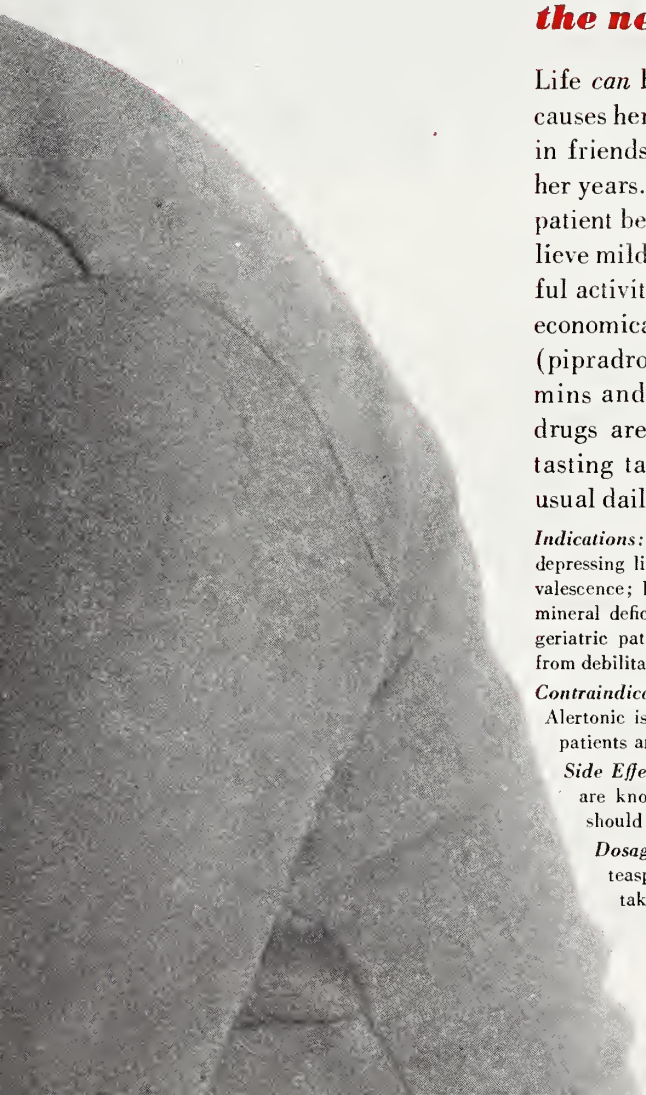
Dimethyl sulfoxide (DMSO) has been mentioned several times because it is an unusual product. It is a chemical solvent that is applied to the skin over a painful joint, muscle arthritic part of the body. The distress is relieved mainly in acute conditions. The Food and Drug Administration did not approve the product because the manufacturer failed to cooperate and because of the unpleasant side reactions and a few reports of more serious adverse effects.

Theodore R. Van Dellen, M.D.

revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio/Weston, Ontario

Merrell



Dr. SIMS in ACTION

ADMINISTRATIVE AND COMMITTEE ACTIVITIES OF THE ILLINOIS STATE MEDICAL SOCIETY

January, 1966

Eliminate 'Pollyanna Attitude' Tuberculosis Committee Told

The Tuberculosis Committee of the Illinois State Medical Society met on October 19; in attendance were: Charles K. Petter, M.D., Chairman; Drs. Kenneth G. Bulley, Clifton F. Hall, Charles A. Lang, David F. Loewen, Karl H. Pfuetze, and Edward A. Piszczek.

To open the meeting, Dr. Petter enumerated the purpose and responsibilities of the Committee as set forth by the Board of Trustees and then reviewed the report made by the Committee last spring, as published in the April 1965 issue of *Illinois Medical Journal.*

It was made apparent that continued effort must be put forth to overcome the "pollyanna attitude" toward tuberculosis. This attitude is evident in the public as well as in a large segment of the medical profession and other health agencies.

X-ray surveys and tuberculin testing as a means of case finding were discussed and emphasis was placed on the importance of tuburculin testing school children in first, fifth and ninth grades when they have their regular physical examinations. Concentration on older individuals and those in contact with active cases was urged as more productive, while continued school-testing, though less productive, is of vital interest. A tuberculin test and/or chest x-ray film are also good health experiences.

Drs. Lange and Bettag are planning a study of the use, accuracy and comparative results of "Hydro-Spray" testing. Drs. Hall and Piszczek reported favorably on this test while Dr. Loewen raised some doubts.

In a discussion on the status of laboratory work, Dr. Piszczek inquired how the new laboratory laws will compel the laboratories to report positive specimens. Pathologists must report positive smears and positive tissues with the name of the patient and the private physican. It is then up to the physician to follow up on the case.

The next meeting of the Committee is scheduled for January 19, 1966 when, among other things, the problem of excess tuberculosis sanitarium beds will come up for discussion.

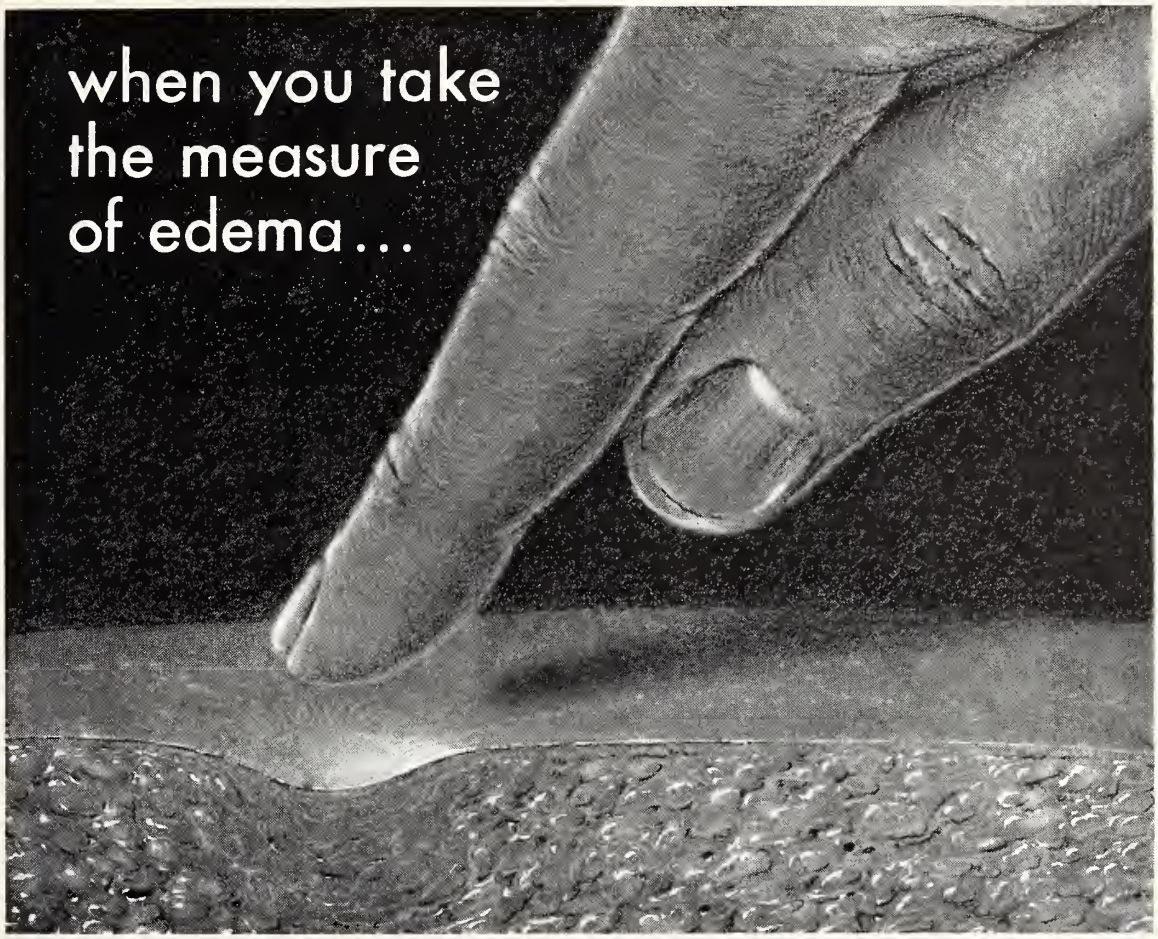
New IBM Billing Procedures Highlight Finance Committee Meeting

The new dues billing form of 1966 was discussed by the Finance Committee of the Illinois State Medical Society which met October 23. It was recommended and agreed that a new procedure would be initiated through electronic data processing services for the year 1966.

Direct billing for county medical societies can be made available to their officers. The initial cost of establishing this program will be approximately $4000 for the first year. In the future the refund provided by the AMA for collecting dues should prove to be adequate to pay for the use of the electronic data processing system.

It was recommended that the Board ap-

continued on page 78



introduce your patient to

aquaTAG®

(BENZTHIAZIDE)

NEW FROM TUTAG for fast, emphatic diuretic action with a balanced excretion of sodium and chloride and a lower potassium loss under normal dosage and diet regimen.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.

S.J. TUTAG & COMPANY
Detroit, Michigan 48234

prove referral to the Constitution and Bylaws Committee the suggestion that the deadline for ISMS dues be changed from April 1 to March 1.

The suggestion was offered that investment consultants be contacted and asked for recommendations on the investment of the reserves which will be available to the Society beginning in 1966. The 1966 dues include $8 per member for this purpose.

In view of the fact that there are approximately 100 members who have not paid supplementary dues for 1965, it was agreed that appropriate letters be sent them advising their delinquency and that this must be paid before their 1966 membership dues will be accepted.

Eight Recommendations Made to Trustees by Legislative Committee

The Legislative Committee of the Illinois State Medical Society, meeting on October 23, made eight recommendations to the Board of Trustees, as follows:

(1) *Participation versus Non-participation:* The committee recommended that the action taken at the special session of the AMA House of Delegates, October 3, be reaffirmed. This position, as interpreted, states (*a*) that an individual physician, acting independently and not in concert with others, may lawfully and ethically elect to treat or not to treat persons under the Medicare program; (*b*) that medicine will oppose any program which will interfere with the physician's freedom of choice with respect to participation or the acceptance of financial arrangements under which he shall provide care. (Approved and endorsed by Board action.)

(2) *Certification - Recertification-Utilization Review:* The actions taken at the special AMA House of Delegates, October 3, should be reaffirmed. These actions would require that current practices and customary procedures with respect to certification of hospital admission and care should be continued under Public Law 89-97 and that hospital utilization committees should be composed of practicing physicians. It is believed that this area will need much more intensive study and that, when further information becomes available, additional recommendations will be made to this Board. (Approved and endorsed by Board action.)

(3) *Carrier:* It is recommended that the Board of Trustees appoint a three man committee to meet with Illinois Medical Service for further details and information and with other potential carriers under P.L. 89-97 as deemed necessary in the judgment of the committee. (Approved and endorsed by Board action.)

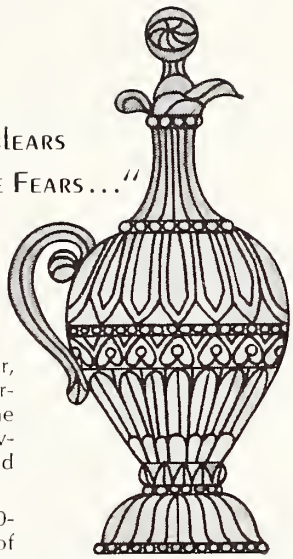
(4) *Specialty Billings:* The committee recommended that the position adopted at the AMA special House of Delegates, October 3, be concurred in. This action, as interpreted, states that the charges for the services of hospital-based specialists should be billed and collected in the same manner as are the fees of other physicians. It is further recommended that the AMA position to vigorously resist efforts to change this provision in the law be supported and that further coordinating meetings with the Illinois specialty groups in this category be sponsored. (Approved and endorsed by Board action.)

(5) *Physician Payment:* ISMS should concur in the actions of the AMA special House of Delegates and that the membership be fully informed as to the provisions of the law and their rights regarding payment. (Approved and endorsed by Board action.)

(6) *Public Aid and Other Governmental Payments:* A policy should be adopted which provides that all governmental programs, federal and state, reimburse physicians according to the usual and customary fee within the community without reference to any existing payment schedule as a basis.

continued on page 80

"Ah, my Beloved, fill the Cup that clears
TODAY of past Regrets and future Fears..."



OMAR KHAYYAM was a tentmaker, astronomer, and wine lover, not a physician. But as you perceive, Doctor, he had a pretty good notion of the value of wine in geriatrics, in anxiety, and in solving many of the problems that beset you and your patients daily.

So, why not let us help you partake of the 900-year-old wisdom of Omar the tentmaker? And of modern medical research? Drop us a note on your professional letterhead and we'll send you, free, "USES OF WINE IN MEDICAL PRACTICE." It's the new, revised summary of a quarter century of research by leading universities and governmental agencies both here and abroad. It highlights the latest findings on wine as a therapeutic aid in your practice, and as an adjunct to the diets of your patients in hospitals and nursing homes.

By the way, Doctor: In your spare time (if any), are you a gourmet cook? Or do you insist that your wife be? If so (or if you just enjoy good food), our new cookbook, "ADVENTURES IN WINE COOKERY BY CALIFORNIA WINEMAKERS," is an absolute must in your kitchen library. We done it and we're proud of it. Our wives helped. It gives you more than 400 irresistible **easy** recipes. Just send us $2 per copy postpaid (we'd love to give it to you but it's too expensive). Makes a wonderful "thank-you-ma'am" or thoughtful gift. Makes doctors and their wives happy. Makes **us** and **our** wives happy. Thank you, Doctor, for listening.

The Winemakers of California

WINE ADVISORY BOARD, DEPT. 102G, 717 MARKET STREET, SAN FRANCISCO, CALIFORNIA 94103

DR. SIMS IN ACTION

. . . *continued*

Reaffirming the existing ISMS positions that medical programs be administered by medically oriented personnel, the committee recommended that the medical aspects of Title XIX and Title II of P.L. 89-97 be administered by the Illinois Department of Public Health. (Approved and endorsed by Board action.)

(7) *Co-ordination on Medicare:* It is recommended that ISMS join with the Illinois Hospital Association in establishing a coordinating committee with the key voluntary and governmental agencies most involved in Illinois. It is further recommended that membership on this committee, in addition to the two sponsoring organizations, include the Illinois Nursing Home Association, Illinois Homes for the Aged, Blue Cross and Blue Shield, Hospital Planning Council of Metropolitan Chicago, the Departments of Public Health, Mental Health and Public Aid, and the Division of Vocational Rehabilitation, plus other groups as the committee deems necessary. (Approved and endorsed by Board action.)

(8) *Continued Study:* The committee recommended that the Committee on Legislation or some other committee, be assigned to conduct the continuing study of all facets of the administration of P.L. 89-97 and its implementation and report to the Board of Trustees at regular intervals. (Approved and endorsed by Board action.)

Numerous bills have been introduced in Congress concerning the care of animals used in research. The committee recommended that the position taken by the AMA be supported. This position states that no additional legislation in this area is needed, and that most of the pending bills will interfere in the research effort. However, if it becomes apparent that some standards of animal care must be established by legislation, approval should be given the Roybal Bill, H.R. 5191, which has been developed in conjunction with the scientific groups involved in medical research.

DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-6408

DUST AS NO "VACUUM CLEANER" CAN!

Revolutionary...and in a class by itself!

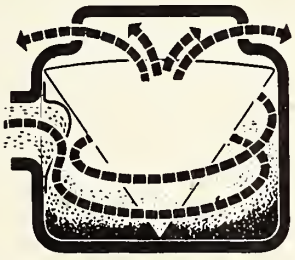
FILTER QUEEN

has the scientific cleaning features that hospitals need most

All "vacuum" cleaners were much the same until the FILTER QUEEN SANITATION SYSTEM was designed. FILTER QUEEN'S patented Sanitary Filter Cone eliminates the need for messy bags, traps practically all airborne contaminants passing into the machine (Harvard Medical School Report in Journal of the American Medical Association, November 25, 1958).*

Experienced hospital housekeepers know this well. That is why FILTER QUEENS have replaced every type of vacuum cleaner in hundreds of hospitals throughout the world.

FILTER QUEEN has no porous bag that permits dust and dirt to reenter the room. FILTER QUEEN operates on an entirely different principle, "Cyclonic Cleaning Action." Here's how it works: Inrushing air, laden with dirt and dust, is deflected by a patented inlet guide as it enters the



container; then is whirled by centrifugal force away from the cone. Dust and dirt are dropped to the bottom of the container. (See illustration.) Air, being lighter, is funnelled to the center of the "cyclone," filters through the Sanitary Filter Cone and returns to the room dust-free.

Why not ask your local FILTER QUEEN Distributor to make the dramatic handkerchief test (pictured at left) in your hospital? There is no better way to prove the improvement in cleaning ability between a FILTER QUEEN SANITATION SYSTEM and any type of vacuum cleaner. (You'll find your distributor listed in the Yellow Pages; or write Health-Mor, Inc. direct).

**We will be glad to send you a reprint of this report on request.*

What hospital administrators say about FILTER QUEEN

"I heartily recommend to any hospital administrator who is presently unhappy with the type of cleaning machine in use, that he try FILTER QUEEN for only two days and the machine will sell itself."

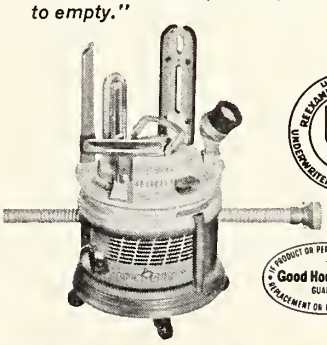
"The FILTER QUEEN is great—a very important factor in patient areas, and is constructed so as to prevent air turbulence of dust at floor level. Filtering of the air, while in general operation, is also a very important and desirable factor."

"One of the most pleasing features of the machine is its quietness. We can even clean in the rooms while occupied by the patients, and many have commented on how pleasant it is not to be disturbed by noisy, old-fashioned vacuum cleaners anymore."

"The air exhaust at the top of the unit is a wonderful feature, and the Sanitary Filter Cone is certainly our answer for working in closely confined patient areas."

"We thought we had a clean hospital and a fairly good method of achieving acceptable sanitation, but this little machine made us revise our thinking and our methods."

"A quiet motor which possesses excellent cleaning power and the convenience of having to clean out the cleaning compartment only once a month, has proved very advantageous. One of the most important points . . . is that there is no bag to empty."



FILTER QUEEN

In Canada: Filter Queen Corp., Ltd., 252 Victoria Street, Toronto, Ont. • **In Mexico:** Industrias Filter Queen, S.A., Av. Jardin #330, Col. del Gas, Mexico 15, D.F.

A Product of HEALTH-MOR, INCORPORATED, 203 North Wabash Avenue, Chicago, Illinois 60601

LOOKING FOR A PLACE TO PRACTICE?

PLACEMENT SERVICE LISTS OPENINGS

Following is a sample of the more than 150 openings for general practitioners listed with the Illinois State Medical Society's Physicians' Placement Service. Interested physicians who register with the service will be provided with a complete list of openings. Inquiries and comments should be directed to: Mrs. Robert Swanson, Secretary, Physicians' Placement Service, Illinois State Medical Society, 360 North Michigan Avenue, Chicago 60601, STate 2-1654.

Henry County: Kewanee: population 17,300 and the trade area includes 50,000 persons. Twelve physicians, including one limited to eyes, one limited to eyes, ears, nose and throat, one well-qualified surgeon, nine general practitioners, four of whom are well past 60 years of age and limiting their practices. Hospitals: St. Francis and Kewanee Public—125 and 100 beds. 53 miles from Peoria. 50 miles from tri-cities (Davenport, Rock Island, Moline). 3 prescription drug stores. Office space is available or will be made available. Primary sources of income: Machinery and Conveyor, 250 employees; Kewanee Manufacturing, 175; Kewanee Boiler Co., 450; Hyster Co. now employs 250, presently building new multi-million dollar facility employing over 500. Many small industries. Kewanee is located in a very wealthy farming area. It is known as the "Hog Capital of the World." Protestant and Catholic churches. 6 grade schools; 2 high schools, public and parochial. Nearest colleges: Bradley, Knox and Augustana. Organizations: Kewanee Association of Commerce and Industry, Rotary, Kiwanis, Lions and Elks. Recreational facilities: Midland Country Club, 9-hole private golf course, 18-hole public course. Finest park system in Illinois. Swimming pools.

Cass County: Beardstown: population 6500. Estimated population of trade area: 18,000. 7 physicians, ages 45, 47, 52, 52, 52, 50 and 59. Two are physically limited; one is attempting gradual retirement. Schmitt Memorial Hospital; 20 beds. 42 miles from Springfield, population 85,000. Two prescription drug stores; a third to open soon. Ambulance service provided by funeral homes. Numerous office facilities including space in Beardstown Clinic if association desired. Predominant nationalities in area: German and Irish. Sources of income: agriculture and small industry. Oscar Meyer plant to open soon—will employ over 200. 16 Protestant and Catholic churches. 4 grade schools—1 high school. Nearest colleges at Jacksonville—28 miles. Organizations include Chamber of Commerce, J. C., Rotary, Womans Club, etc. Recreational facilities include 2 golf courses, boat harbor on Illinois river, swimming pool, good park facilities, good fishing and hunting.

Dekalb County: Kirkland: population 1,000. Estimated population of trade area, 4,500. Several small towns in the area without physicians. One practicing physician—urgent need for a second. Nearest hospitals at Belvidere and Sycamore, 12 and 15 miles. Nearest large city—Rockford—25 miles. Population: 128,000. One prescription drug store. Source of income—industry and agriculture. Lutheran and Methodist churches. Grade and high schools. Nearest college, 18 miles. Organizations include: PTA, Lions, Civic Improvement, Home Bureau, etc. Town has supported two physicians for many years. Modern type medical building has recently been erected as suggested by the Sears Foundation.

Champaign County: Mahomet: population 1500. 10,000 population expected by 1980 due to nearby Lake of the Woods area. Only physician recently died. Community has always supported one or more physicians. Nearest physicians at Champaign-Urbana—11 miles. One local prescription drug store. Widow of deceased physician owns office; willing to rent it equipped if desired. 6 rooms; X-ray equipment in basement. Write to Mrs. Ernest Moon re office and equipment. Largely protestant community. Over 50% of the residents are employed at the University of Illinois. Good agricultural area. Churches: 2 Baptist, Methodist and Nazarene. Grade, Jr. High and High schools. 1200 students in school system. Organizations include Boosters Club, Womens Club, Odd Fellows and Masonic Lodge. Lake of the Woods, with 18 hole golf course, swimming pool, etc. is at the city limits. 500 acre park. Deceased physician had 700 patients, 40 office calls daily.

ISMS 126th ANNUAL CONVENTION



May 15-18 Sherman House, Chicago

SCIENTIFIC SESSIONS

MONDAY, MAY 16	
9:00 a.m.	Occupational Health Illinois Obstetrics-Gynecology Society
1:30 p.m.	Section on Surgery Section on Anesthesiology Section on Neurology and Psychiatry
TUESDAY, MAY 17	
8:30 a.m.	Section on Obstetrics-Gynecology Section on Allergy Section on Internal Medicine
1:30 p.m.	Section on Public Health Section on Radiology Section on Physical Medicine
WEDNESDAY, MAY 18	
8:30 a.m.	Section on EENT Section on Pathology Section on Dermatology Section on Pediatrics
2:00 p.m.	Camp Lecture
3:00 p.m.	Pathology Slide Seminar

Interested in setting up a Scientific Exhibit? For information and applications contact: Coye Mason, M.D., 2852 North Orleans, Chicago, Illinois.

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT



SUCCESS STORY

"Nothing succeeds like success" might well be the sub-motto for the American Association of Medical Assistants. For soon after the formation of the first state organization of medical assistants, the idea of a national association began to grow. In 1955 the Kansas Medical Assistants Society invited all interested medical assistants to meet in Kansas City and consider forming a national society. Seventy-eight people from 15 states responded. All had been active in local and state groups and could see the value of a national association. Many of the delegates came without specific instruction from their home groups, so a Steering Committee was appointed to handle the details of organizing.

In October 1956, 156 women, representing 13 state and local groups, met in Milwaukee, Wisconsin. Physicians and representatives of the American Medical Association served as advisors at this meeting. A constitution and bylaws were adopted and officers elected. Maxine Williams was chosen as the first president of the new association, known as the American Association of Medical Assistants. In November 1956, this association had its objectives commended in a resolution passed by the AMA House of Delegates.

By the time of the first annual meeting there were 19 active state associations. In many areas ground work was started for educational courses, in-service training programs, workshops and seminars. By the third annual conventions the roster showed 23 member states and 7,000 members. Last October, when the ninth annual meeting was held in New York City, the number of member states had risen to 43, plus the District of Columbia, and the membership passed the 15,000 mark.

At the time the AAMA was being formed in 1955, the American Medical Association encouraged Illinois to form a state association when it was learned that there were local groups in Quincy and Chicago. The two societies held an organizational meeting in Springfield, June 3, 1956. Fifty-eight women from the Quincy and Chicago societies adopted and signed a constitution. The new association was called the Illinois State Medical Secretaries and Assistants Association until June 1957 when the name was changed to Illinois Medical Assistants Association.

At the ninth state convention held in East Peoria last April, Illinois had 13 county societies in its membership roll and 437 members. More than 150 members attended this meeting.

This month members are again enrolling for the coming year. We invite all interested medical assistants to join us for 12 months of fellowship and education. If your medical assistant is not a member, why not encourage her to join? If there is no chapter in your area, write to IMAA, 360 N. Michigan Ave., Chicago 60601 for information on how to form one. We'd like to get to know her.



Do doctors have special insurance needs?

PROTECTION · SECURITY · RELIABILITY

Life of America

thinks so...which is why we have developed our *new* INCOME PROTECTION PLAN for professional men.

As a doctor, your income far exceeds the national average . . . and so should your income protection plan. It should offer monthly benefits that realistically approximate your own income when you are unable to continue your practice. And should your disability last a few years, or even a lifetime, you should have the peace of mind that comes from knowing that adequate provisions have been made for your future financial security.

These are the special insurance needs that a doctor has . . . and will receive from life of America's new Income Protection Plan. The assurance that when you need protection, Life of America will provide it, if need be, for the rest of your life. Perhaps, after speaking with one of our representatives, you will better understand why we say: Tomorrow's security begins today with THE LIFE OF AMERICA INSURANCE COMPANY.

LIFE OF AMERICA INSURANCE COMPANY • 1 EAST WACKER DRIVE • CHICAGO, ILLINOIS 60601



Rx Reviews

and New Products

Non-Sterile Disposable Examination Gloves



New disposable plastic examination gloves that are less constricting than rubber gloves, yet designed for extreme sensitivity are now available from the Disposable Products Division of Howe Sound Co., New York. The non-sterile, water tight and hospital clean, medically pre-powdered gloves can be used as a physician's examining gloves, and for changing dressings in laboratory, kitchen or the home. Each glove is mounted on an individual paper sheet for easy dispensing and disposing, and sell for as low as two cents/pair when purchased in large quantities. Additional inquiries should be addressed to the Howe Sound Co., Disposable Products Division, 22-28 S. 6th Ave., Mount Vernon, N.Y., 10550.

New Dosage Forms

Roche Laboratories, a division of Hoffmann-La Roche, Inc., has just introduced two new dosage forms.

Tensilon (edrophonium) ampuls is a new dosage form of a drug used in myasthenia gravis and as an antidote to curare. Available in packages of ten, each 1 cc ampul contains 10 mg of Tensilon (edrophonium). The product was formerly available only in multiple dose 10 cc vials.

Clinical studies have shown that the drug, a cholinergic agent which acts primarily on striated muscle, is useful for diagnosis and evaluation of treatment requirements in myasthenia gravis. It is also a potent curare antagonist which acts within one minute and has a brief duration of effect. Tensilon (edrophonium) will continue to be available in 10 cc multiple dose vials, 10 mg. per cc.

Just introduced is Ganatol (sulfamethoxazole) Suspension, a new dosage form of a widely used sulfonamide. This product is effective in the treatment of respiratory and urinary tract infections due to susceptible micro-organisms and is particularly useful for pediatric patients.

Ganatol (sulfamethoxazole) Suspension is of value in a wide range of bacterial infections of the respiratory and urinary tracts due to susceptible micro-organisms; e.g., pharyngitis, otitis media, tonsillitis, sinusitis and pyelonephritis. It is effective in a convenient, oral, twice-a-day dosage.

Device for Visually Examining Middle Ear

A device which permits physicians to visually examine the middle ear with a minimum amount of discomfort to the patient is now being developed at the University of Illinois College of Medicine in Chicago.

Devised by Dr. S. Bruce Mer, a resident and National Institutes of Health trainee in the Department of Otolaryngology, the endotoscope was developed under his direction by optic physicists at the Illinois In-

continued on page 94

Forest Hospital is an intensive care psychiatric facility noted for its advanced, comprehensive treatment programs. One such program is its psychiatrically based **marriage counseling service,** which provides psychotherapy for couples whose interpersonal conflicts are based upon marriage problems. A teaching program is conducted by the clinic for psychiatrists, physicians, psychologists, social workers and others whose professional responsibilities impose upon them the necessity to acquire special skills in helping married people in trouble.

Forest Hospital is accredited and is 25 minutes from downtown Chicago.

555 Wilson Lane,
Des Plaines, Illinois
Dial 827-8811

MARITAL CLINIC
Dr. Bernard L. Greene, Director

This is one in a series of advertisements describing some of the services offered at the hospital.

The alcoholic *CAN* be rehabilitated

With a unique background of 80 years' experience, The Keeley Institute has earned an international reputation as a specialized hospital for the *restorative treatment* of the "problem drinker."

Our progressive, well-rounded regimen includes:

- gradual withdrawal
- physical rehabilitation
- re-orientation
- re-education

Individual and group care are conducted in a friendly, cooperative atmosphere under the direction of physicians and experienced personnel. *We take female as well as male patients.*

Write for detailed, descriptive information on our low cost, comprehensive services—or phone 815 584-3001. We welcome your referrals.

THE KEELEY INSTITUTE
Dwight, Illinois
Member American Hospitol Association
Member Illinois Hospital Association
Licensed by the Department of Public Health,
State of Illinois

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
Starting Dates — 1966

SPECIALTY REVIEW COURSE IN OB-GYN, Two Weeks, March 21
SPECIALTY REVIEW COURSE IN SURGERY, Part II, March 7
SPECIALTY REVIEW COURSE IN ORTHOPEDICS, April 18
SPECIALTY REVIEW COURSE IN MEDICINE, Part II, February 28
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
GALLBLADDER SURGERY, Three Days, March 7
SURGERY OF HERNIA, Three Days, March 10
TREATMENT OF VARICOSE VEINS, One Week, February 14
PROCTOSCOPY & SIGMOIDOSCOPY, One Week, February 14
FLUIDS & ELECTROLYTES, One Week, March 28
THORACIC SURGERY, One Week, March 28
ARTERIOGRAPHY, Four-Days, February 8
VAGINAL SURGERY, One Week, February 14
BASIC ELECTROCARDIOGRAPHY, One Week, March 14
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates
Informal Clinical Programs in Fractures, Orthopedics, Pediatrics, Dermatology, Gynecology, Otolaryngology, and Ophthalmology, One to Two Weeks, starting the first of any week.

Information concerning numerous other continuation courses available upon request.

TEACHING FACULTY
Attending Staff of
Cook County Hospital

Address: REGISTRAR, 707 South Wood Street
Chicago, Illinois 60612

What Can
PROFESSIONAL FARM MANAGEMENT Do For You?

It can provide expert analysis of farm operations and take the worry out of farm ownership from purchases to profits.

Completely qualified by training and experience, professional farm managers can assist you or your client with farm problems—planning and supervising the farm operation, selecting tenants, buying supplies, selling products, deciding on government programs. Accredited Farm Managers (A.F.M.) available.

For a complete list of managers, write to:

**Mr. F. M. Sims, Secretary-Treasurer,
Illinois Society of Professional Farm Managers and Rural Appraisers,
305-D Mumford Hall, University of Illinois
Urbana, Illinois 61803**

APPLICATIONS ACCEPTED NOW FOR SCIENTIFIC EXHIBITS ISMS CONVENTION

MAY 15-18 SHERMAN HOUSE, CHICAGO

For information and forms write:

**Coye Mason, M.D.
2852 North Orleans, Chicago, Illinois**

Reviews and New Products

. . . *continued from page 92*

stitute of Technology Research Institute.

A small incision on the eardrum of the locally anesthetized subject, permits the otologist to insert the small, round 2.5 mm-diameter probe into the middle ear. The tip of the probe is electronically illuminated so the physician is in a position to observe the functioning ear through an attached surgical microscope or obtain photographs by means of an attached camera.

The device permits direct viewing and exploring of the middle ear. While the endotoscope is still in its early stages of development and has had limited use on humans, experiments and observations on animals indicate the unit may become valuable in diagnosing diseases and abnormalities of the middle ear, observing normal functioning of pre- and post-surgical conditions, as well as the presence of anatomical variations. The instrument offers direct evidence of middle ear disease, which, until now, had to be inferred from indirect evidence by otoscopic observation or seen at surgery.

The instrument itself is made of a bundle of optical fibers with a small lens mounted at the end. The lens and fibers are surrounded by another ring of fibers which conveys light into the field on which the lens focuses. This outside fiber ring contains a hollow tube with an electrode inside it which can be directed by the otologist to come into direct contact with muscle or membrane while the endotoscope is being used.

The instrument is therefore capable of transmitting and recording microphonic changes in the middle ear.

Further development of the unit is being carried on by Dr. Mer and Dr. Arthur J. Derbyshire, research associate professor of otolaryngology, at the Illinois Eye and Ear Infirmary, Chicago. The entire project is under the direction of Dr. Francis J. Lederer, professor and head of the University of Illinois Department of Otolaryngology.

Meeting Memos



January 21—The University of Chicago is sponsoring a Clinical Cancer Conference on "Carcinoma of the Lung" to be held in Billings Hospital, Room P-117, from 5:00 to 6:00 p.m. The case will be selected and presented by Dr. William F. Adams, Professor, Department of Surgery. Participants in the conference will be Drs. William R. Barclay, Professor, Department of Medicine; James W. J. Carpender, Professor, Department of Radiology; George L. Wied, Associate Professor, Department of Obstetrics and Gynecology.

February 7-10—The American College of Physicians is presenting its Postgraduate Course No. 10 at Jefferson Medical College and Medical Center, Philadelphia, Pennsylvania. The course, "Current Concepts of Infectious Disease," is designed to review basic principles of infectious diseases as related to diagnosis and management. New knowledge in the fields of microbiology and immunology and in the utilization of antibiotics and chemotherapeutic agents will be discussed and techniques of diagnostic procedures will be demonstrated.

Registration forms and request for information should be sent to Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

March 15—"Witchcraft and Primitive Medicine" is being presented by the International College of Surgeons as part of its Tenth Lecture Series at 1524 Lake Shore Drive, Chicago, 8:00 p.m. The speaker will be Dr. John Middleton, former Professor, University of London and University of Cape Town, South Africa; field researcher in Uganda, Zanzibar and Nigeria; Professor, Department of Anthropology, Northwestern University.

VACANCY FOR ASSOCIATE MEDICAL DIRECTOR

This position in a large company offers opportunity for advancement and has a modern benefit program. Salary open.

Applicant may be a generalist with a sincere interest in industrial type practice, or have special training or have specialty board certification in Preventive Medicine.

Applicant must have Indiana license or be eligible for same and be in good health.

This is an excellent opportunity in Occupational Medicine which should be investigated to appreciate.

CONTACT: Joseph T. Noe, M.D.
Medical Director
Inland Steel Company
Indiana Harbor Works
East Chicago, Indiana 46312

Telephone: 397-2300, Ext. 2577
Area Code: 219

INLAND

An Equal Opportunity Employer
In The Plans for Progress Program

INDUSTRIAL PHYSICIAN
•
GENERAL PRACTITIONER

Immediate opening for experienced Industrial Physician or General Practitioner for full time staff position in modern, well established medical division of large Central Illinois heavy industrial plant. Must be able to handle minor surgical cases and medical emergencies.

Attractive benefit program. Salary open.

Send detailed resume in confidence to:
Box I-480

An Equal Opportunity Employer

OBITUARIES

Robert S. Berghoff*, Chicago, died December 26, aged 76. A graduate of St. Louis University School of Medicine in 1913, Doctor Berghoff became a well known heart specialist. During his career he held positions at Loyola University, Mercy and County hospitals and the Board of Education. At one time he was president of ISMS and he later became a member of the Fifty Year Club.

DeWitt T. Brown*, Mulberry Grove, died November 27, aged 83. He was a graduate of Barnes Medical College, St. Louis in 1903. He was a member of the Fifty Year Club of ISMS.

Anthony F. Caravelli, Downey, died September 12, aged 49. He was a graduate of St. Louis University School of Medicine in 1942.

Robert H. Carmichael*, Tinley Park, died November 20, aged 80. A graduate of Wayne State University College of Medicine, Detroit, in 1907, he was past president of Southern Cook County Medical Society. He had been a staff member of St. Francis hospital and served as Rock Island railroad physician and surgeon. He was a member of the Fifty Year Club of ISMS.

Arthur B. Curry*, Tennessee, formerly of Decatur, died the week of November 21st, aged 82. A graduate of Loyola University School of Medicine in 1914, he was past president of Jersey County Medical Society. He was also a member of the Fifty Year Club of ISMS.

Frederick F. Garrison*, Aurora, died December 19, aged 90. He was a graduate of Rush Medical College in 1904. He was a member of the Fifty Year Club of ISMS.

J. Roscoe Herry*, Chicago, died December 6, aged 79. A graduate of Rush Medical College in 1914, he was a staff member of Henrotin hospital for 51 years. He also served on the staffs of Ravenswood and Illinois Masonic hospitals. He was a member of the Fifty Year Club of ISMS.

Kenneth H. Keeton*, California, formerly of Quincy, died October 26, aged 41. A graduate of Northwestern University Medical School in 1951, he specialized in internal medicine.

Paul Kent*, Brockton, Massachusetts, formerly of Chicago, died December 22, aged 75. A graduate of Chicago Medical School in 1923, Doctor Kent retired in June of 1965. He was the founder and builder of Anna Memorial, now Northwest hospital and a staff member of Columbus hospital.

Ceslovas Kizliuskas*, Winchester, originally from Lithuania, died November 1, aged 42. He was a graduate of Medizinische Fakultat der Georg-August-Universitat, Germany, in 1949. He was on the staffs of both Holy Cross and Passavant Memorial Area hospitals.

Abraham E. Lunn*, Oak Lawn, died September 28, aged 81. In 1912 he was a graduate of Chicago College of Medicine & Surgery. He was a member of the Fifty Year Club of ISMS.

Theodore J. Morris*, Evanston, died November 20, aged 66. A graduate of Northwestern University Medical School in 1925, he specialized in obstetrics and gynecology. Doctor Morris was a staff member of Passavant Memorial and St. Francis hospitals until his retirement in 1959.

Michael Nakutny, Arlington Heights, died November 27, aged 43. He was a graduate of Loyola University School of Medicine in 1947.

Louis D. Popuch*, Chicago, died November 28, aged 51.

Eli Siegel, Chicago, died December 6, aged 67. He was a graduate of Chicago Medical School in 1927.

Henry S. Testin*, Chicago, died November 18, aged 72. A graduate of the University of Illinois College of Medicine in 1926, he retired in 1962. He had been a staff member of South Chicago Community hospital.

Udell Thimsen*, East St. Louis, died November 28, aged 50. A graduate of St. Louis University School of Medicine in 1942, Doctor Thimsen specialized in pediatrics.

**Indicates member of Illinois State Medical Society.*



a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).

IMJ

Illinois Medical Journal

CONTENTS

volume 129, no. 2 *February, 1966*

ABSTRACTS OF BOARD ACTIONS 107

MEDICAL PROGRESS

Liver Functions in Clinical Medicine, Part I
Frederick Steigmann, M.D., Chicago.....139

CLINICAL ARTICLES

Benign Bronchoesophageal Fistula Associated with a Traction Diverticulum of Esophagus
Irving Weissman, M.D., et al, Urbana.....127

The Predicament of the Aged
Eric C. Kast, M.D., Chicago.....132

Two Foreign Bodies of the Appendix: A Case Report
R. J. Maganini, M.D. and Wayne Mathy, M.D., Berwyn.....137

Control of Gastric Hemorrhage with Gastric Hypothermia
George S. Schwerin, M.D., Chicago.....146

Treatment of Hypertension in Pregnancy
John W. Pollard, M.D., and Thomas R. Wilson, M.D., Urbana 153

Preparing a Paper on Drug Therapy: Basic Principles
Harold D. Kautz, M.D., North Chicago.....158

Polyneuropathy Due to Nitrofurantoin
Richard F. Herndon, M.D. and Gerald E. Fox, M.D., Urbana 164

FEATURES

President's Page 116
Editorials 174
Health Careers Council.....180
Book Reviews 182
Dr. SIMS in Action.....188
IMAA Reports 189
New Products 194
Meeting Memos 196

Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Ill. 60601. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.50 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies available at cost of 75 cents. Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.
Copyright 1966, The Illinois State Medical Society.

too young
to be so tired...



ABSTRACTS OF BOARD ACTIONS

MEETINGS OF JANUARY 15-16, 1966

BOARD APPROVES 1966 BUDGET

Members of the Finance Committee, sitting as a panel, discussed details of the budget for 1966. The budget, based on annual dues from members in the amount of $105, provides for a contingency reserve fund of $19,900. According to Dr. Carl Clark, chairman of the committee, a similar budget for 1967 is anticipated. After all members of the Board of Trustees were given an opportunity to question the Finance Committee and comment on the budget, it was approved.

Program chairmen note:

The Finance Committee members expressed a willingness to appear before county medical societies to discuss the budget and services. Requests should be addressed to the Executive Administrator of the Society.

SOCIETY TO CONDUCT LEADERSHIP CONFERENCE

A Leadership Conference will be held Wednesday and Thursday, April 27th and 28th at the Holiday Inn East in Springfield. It will replace the traditional "secretaries conference" and will acquaint all county medical society officers and committee chairmen with the activities of the Illinois State Medical Society. Details will be sent to all concerned.

SCIENTIFIC EXHIBIT AWARD TO CARRY CASH PRIZE

The Board of Trustees has approved a proposal from Mead Johnson & Co. to give a cash prize of $200 and a plaque for the best scientific exhibit at the annual ISMS convention. The award will be decided by regular ISMS committee of judges.

"USUAL AND CUSTOMARY FEES" DEFINED

For the purposes of implementing "Medicare" and other governmental medical programs, the Board of Trustees has approved the following definitions:

USUAL—The "usual" fee is that fee usually charged for a given service by an individual physician to his private patient.

CUSTOMARY—A fee is "customary" when it is within the range of the usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area.

REASONABLE—A fee is "reasonable" when it meets the above two criteria, or in the opinion of the responsible local or district and state medical society review committee, is justifiable, considering the special circumstances of the particular case in question.

HOUSE TO GET MUSEUM REQUEST

A request from the Archives Committee to extend a special dues allocation for 15 years to raise $150,000 for the Lincoln shrine in Springfield will be referred to the House of Delegates without recommendation. The 1965 House authorized $1.00 per member be allocated from dues over a five-year period for the museum, providing substantial funds could be obtained from other sources. These outside sources have not been found.

ABSTRACTS OF BOARD ACTIONS---(CONT'D)

MEETING OF JANUARY 15-16, 1966

APPROVE DEFINING NURSE'S ROLE

On recommendation of the Committee on Nursing, the Board has approved in principle a statement that hospitals and other health agencies should develop written criteria and policies for determining the role and responsibility of the doctor and of the nurse in performing certain procedures in the care of patients.

SUGGEST "HEAD START" CHANGES

On recommendation of the Child Health Committee, the Illinois State Medical Society will request that in future "Head Start" operations, the Office of Economic Opportunity make it "mandatory that a physician be included on each local planning committee, that all medical care and examinations be provided, if feasible, by private physicians in their own offices, and that the funds allocated must be realistic in terms of the nature of the examination required."

MATERNAL AND PERINATAL STUDY NEEDS FUNDS

The Board of Trustees has ruled that no public funds be used to finance the proposed statewide study of maternal and perinatal mortality. The Educational and Scientific Foundation of the Society will make a concentrated effort to secure $150,000 to $200,000 from private sources for this purpose.

"GAS LIGHT PARTY" PLANNED FOR CONVENTION

Changes in format for the 1966 convention, to be held May 15-18 at the Sherman House in Chicago, include discontinuing the annual banquet and scheduling a "Gas Light Party" for Tuesday evening. The party will have entertainment, a floor show, etc., from 8:30 to 11:30 p.m. at a cost of $5.00 per person.

CHANGES IN STUDENT LOAN PROGRAM REFERRED TO HOUSE

After prolonged discussion of the Student Loan Fund, which is administered jointly by the Illinois State Medical Society and the Illinois Agricultural Association, the ISMS Board of Trustees refused to accept more flexible contract provisions suggested by the Committee on Rural Health and Student Loan Funds, and the proposed changes will be included in the committee's annual report to the House of Delegates. Participants in the Student Loan program now sign contracts agreeing to enter general practice in an Illinois town having a population of 5,000 or less; the committee is suggesting that the provision be liberalized with respect to the size of the town in which the loan recipients must practice and that the restriction against specialization be removed.



with Soma® Compound

carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg.

In most patients with strains and sprains, 'Soma' Compound can reduce recovery time because of its ability both to relieve pain and to relax muscle. In a controlled study of patients in an industrial practice, R. G. Conant reported that 'Soma' Compound shortened recovery time an average of 25% as compared with aspirin.[1] In addition, complete or marked relief was noted in 94% of patients treated with 'Soma' Compound, as compared to 46% of patients treated with aspirin.

1. Conant, R. G.: Reduction of industrial time-loss: treatment with carisoprodol compound in musculoskeletal disorders. Industr. Med. Surg. *33*.25, Jan. 1964.

Also available with ¼ gr. codeine as 'Soma' Compound with Codeine: carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

Indications: 'Soma' Compound and 'Soma' Compound with Codeine are useful for relief of pain and stiffness in traumatic, rheumatic and other conditions affecting muscles and joints. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol, phenacetin, or codeine phosphate. **Precautions:** *Phenacetin*—With long-term use, give cautiously to patients with anemia and cardiac, pulmonary, renal or hepatic disease. May damage the kidneys when used in large amounts or for long periods. *Caffeine*—Not recommended for persons extremely sensitive to its CNS stimulating action. *Codeine phosphate*—Use with caution in addiction-prone individuals. *Carisoprodol*—Carisoprodol, like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g. meprobamate. **Side effects:** Drowsiness, lightheadedness, dizziness, and gastric complaints have been reported infrequently for either or both of these preparations. *Phenacetin*—Side effects are extremely rare with short-term use of recommended doses. Prolonged ingestion of overdoses may produce dyspnea, cyanosis, hemolytic anemia, skin rash, anorexia, subnormal temperature, insomnia, headache, mental disturbances, and tolerance. *Caffeine*—Side effects are almost always the result of overdosage. Average doses may rarely cause nausea, nervousness, insomnia, and diuresis. Excessive dosage may produce, in addition, restlessness, nervousness, tolerance, tinnitus, tremors, scintillating scotomata, tachycardia, and cardiac arrhythmias. *Codeine phosphate*—Possible side effects are nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms. One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reaction, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression. **Dosage:** Usual adult dosage of 'Soma' Compound or 'Soma' Compound with Codeine is one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white capsule-shaped tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

WALLACE LABORATORIES / *Cranbury, N. J.* CSO-5155



Burtis E. Montgomery, M.D.

president's page

MEMBERSHIP SURVEY WILL RE-STATE ISMS MISSION

By the time you receive your *Journal* this month, you may already have been interviewed by a representative of the Opinion Research Corporation; if not, you may be approached by an interviewer in the very near future. We hope that the purpose of this survey of membership opinion has been made clear to you and its importance emphasized so that the survey team will be given the fullest cooperation by all members of the Society asked to participate.

The survey, arranged by the Board of Trustees, has my strongest endorsement. It is a means by which members of the Illinois State Medical Society can re-state the mission of their society.

Five years ago our mission was stated through another type of survey which resulted in a complete reorganization of the society and included a fast expansion of its activities. Since that time, of course, the profession has experienced significant changes scientifically and politically. And it is time again for the membership to express itself regarding our program so that your officers and trustees can undertake activities over the next five years to further the goals of physicians in Illinois for providing the best possible health care for the people of this great state.

Your officers and board are convinced that the mission of the society must be re-stated from time to time in accordance with changing conditions and they are depending upon this comprehensive survey to provide guidelines for this re-statement through your frank appraisal of the society's activities via questions presented by professional, confidential interviewers.

After the personal interviewing has been completed the research firm will confirm its findings by obtaining the opinion of a larger group of doctors through written questionnaires. If you are selected for a personal interview or are asked to complete a written questionnaire, I hope you will enter into the project conscientiously and enthusiastically, realizing that your earnest attention to the way your answers are given will be important in the shaping of your society's future.

IMJ

Illinois Medical Journal

volume 129, number 2 February, 1966

BENIGN BRONCHOESOPHAGEAL FISTULA ASSOCIATED WITH A TRACTION DIVERTICULUM OF ESOPHAGUS

*Irving Weissman, M.D.,**
Lawrence M. Hursh, M.D.,†
Jack C. Cooley, M.D.† and*
*Thomas O. Vechinski, M.D.**/urbana*

MOST RESPIRATORY ESOPHAGEAL fistulae are seen in infants and are congenital in origin usually associated with various forms of esophageal atresias[13]. In the adult, such fistulae are either the result of neoplasm with invasion and erosion or are traumatic in origin. A spontaneous bronchoesophageal fistula unassociated with trauma or malignancy in the adult is extremely rare[1,2,3,6,7,8,11,12,13,14,15,18]. Early and accurate diagnosis is important since fatal hemorrhage may occur and inasmuch as the abnormality is amenable to surgical correction. In the case presented here as well as those reported in the literature, the primary clinical symptoms appear to refer mostly to the respiratory system: cough, hemoptysis, dyspnea, etc. resulting in a failure to investigate the esophagus. The underlying etiology may remain obscure until the esophagram is accomplished. The presence of a traction diverticulum in the esophagus along with a history of hemoptysis may be the clue to a bronchoesophageal fistula or its impending development. This case is being reported, therefore, to emphasize the importance of investigating both the esophagus as well as the respiratory tract particularly in cases of hemoptysis of unknown origin.

Report of Case

J.L.C., a 25 year old white male, gave a history of developing pneumonia in the spring of 1958, while a student at Purdue University. In 1959, the patient had his first bout of hemoptysis which has recurred every three or four months, usually lasting about a week. Hemoptysis began with three

*Consulting Radiologist, University of Illinois Health Service and McKinley Hospital, Urbana, Illinois. †Associate Director, University of Illinois Health Service and McKinley Hospital, Urbana, Illinois. *†Cardio-thoracic Surgeon, Carle Hospital Clinic, Urbana, Illinois. **Senior Resident in Radiology, University of Wisconsin General Hospital, now in Armed Services.

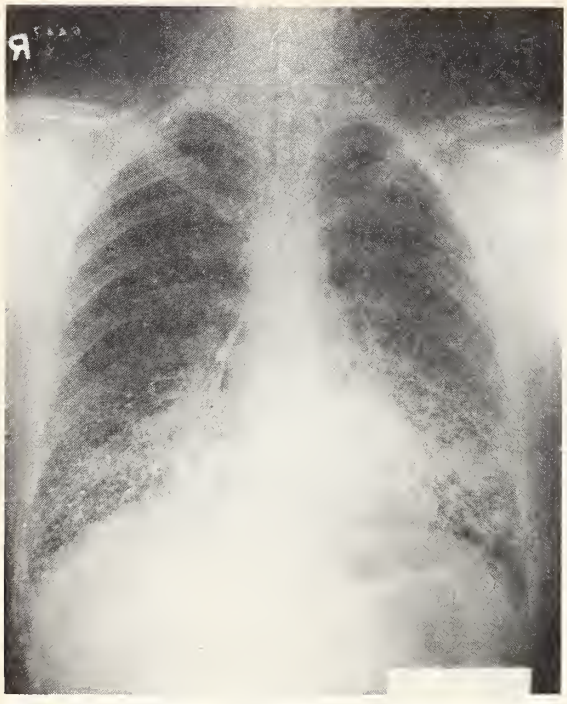


Figure 1. Normal bronchogram showing no significant defects.

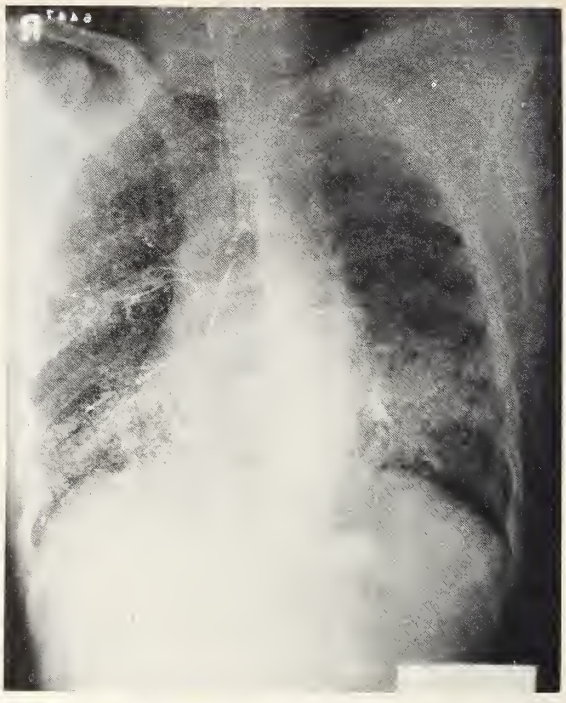


Figure 2. Normal bronchogram—note the intact right main stem bronchus.

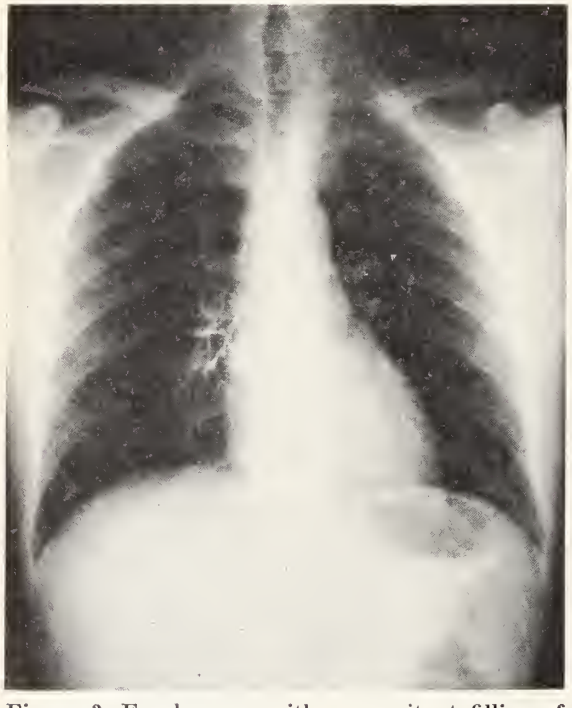


Figure 3. Esophagram with concomitant filling of right lower lobe bronchus.

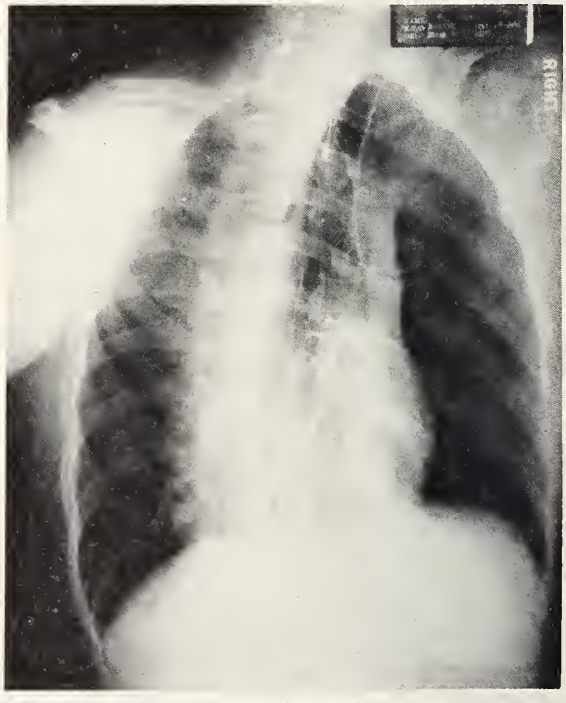


Figure 4. Esophagram with filling of right lower lobe bronchus and reflux into trachea.

or four mouthfuls of blood and then gradually subsided over the next several days. The bleeding was usually associated with very little additional chest symptoms. There was no cough, fever or significant chest pain. While at Purdue University in April, 1960, following an episode of bleeding, bronchoscopy and bronchography were done and reported as early bronchiectasis in the right lower lobe. Repeat of these examinations in November, 1960, failed to confirm bronchiectasis and all findings were recorded as normal. The patient remained asymptomatic until June, 1962.

While a student at the University of Illinois hemoptysis recurred in September, 1963, and in February, 1964. Repeated bronchoscopy and bronchography accomplished at the University of Illinois, McKinley Hospital Health Service were reported as either normal or early suspect bronchiectasis in a right lower lobe bronchus (Figures 1 and 2). On August 3, 1964 the patient complained of dysphagia for the first time, following two rather severe episodes of bleeding. An esophagram revealed a small traction diverticulum in the middle third of the esophagus from which an irregular fistulous tract was visualized with opacification of the right lower lobe bronchus. Barium entering the bronchus produced coughing and reflux of the opaque medium into the trachea (Figures 3, 4, 5 and 6). It should be noted that there was nothing in this patient's past history to suggest an underlying cause for the development of a bronchoesophageal fistula. The tuberculin skin test was negative and sputa examinations showed no evidence of tubercle bacilli. Blood values and urinalysis were normal.

Thoracotomy Performed

On September 22, 1964 a right thoracotomy was done. The right lung was carefully inspected for areas of consolidation, bronchiectasis and pneumonitis. No abnormality was found. The esophagus was attached to the respiratory tree in the area of the intermediate bronchus on the right. A fistulous tract entered the lower lobe

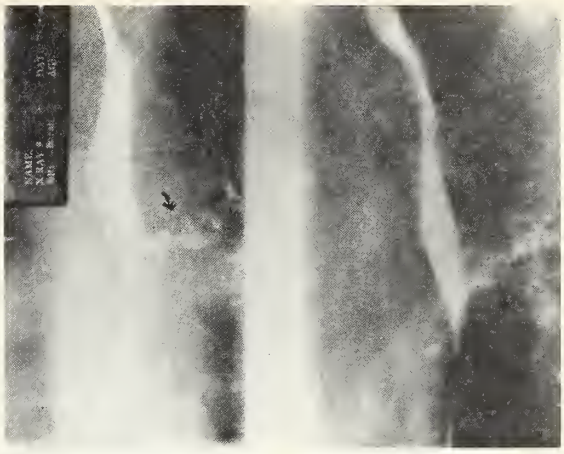


Figure 5. Esophagram, spot view of traction diverticulum.

bronchus just above the origin of the superior segment bronchus. The bronchoseophageal fistula was resected without difficulty (Figure 7). The postoperative course was uneventful and the patient was discharged on the ninth postoperative day. The pathological report indicated an inflammatory tract with the specimen showing both bronchial as well as esophageal components (Figure 8).

Comment and Review of Literature

It is generally conceded that the traction diverticulum in the esophagus, arising usually from an inflammatory process, may on rare occasion erode and produce a bronchoesophageal fistula. Traction diverticula without fistula are, of course, very common. Although the radiologist is likely to be the first to make the diagnosis of fistula associated with a diverticulum in the esophagus, there is very little reported in the radiological literature. On the other hand, a complete discussion of the disease, its symptoms, etiology, and treatment is fully covered in the world literature pertaining to thoracic surgery. Minkari[14] reporting a case of fistula associated with a traction diverticulum quotes Rokitansky in stating that an inflammatory process, while most often tuberculous may be nonspecific in a tracheobronchial lymph node giving rise to adhesions between the involved node and neighboring segment of esophagus. A traction diverticulum develops as a result of

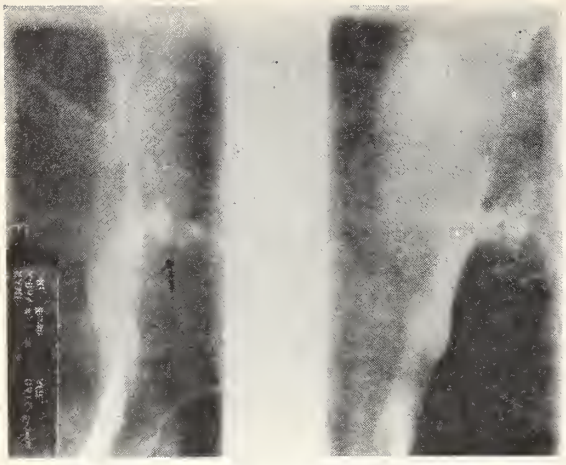


Figure 6. Esophagram, spot view of details of diverticulum with inflammatory tract leading to bronchus.

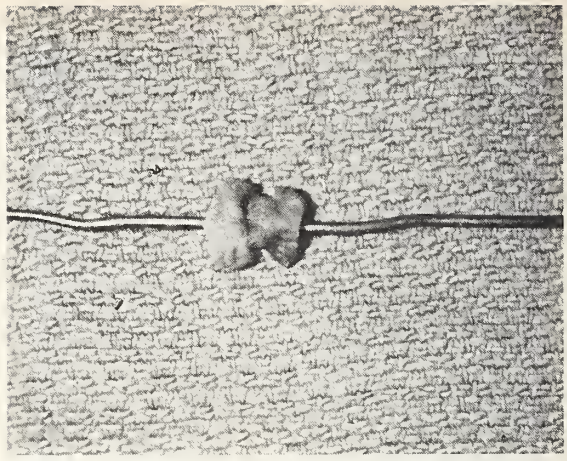


Figure 7. Surgical specimen showing probe extending through resected inflammatory tract.

healing with fibrosis and retraction of the wall of the esophagus. Caseation leading to perforation into neighboring bronchial and esophageal segments may well be the mechanism for the production of a bronchoesophageal fistula. Shope and Petersdorf[16] describe in great detail a case of mediastinal tuberculosis in a 29 year old Negress in which erosion of a caseous lymph node appeared to have spread to the pericardium and also produced an esophageal fistula. These authors state that a review of world literature in 1949 revealed 75 cases of reported benign respiratory fistulae, 14 of which were tuberculous in origin. Levine[10] reporting a case of fistula associated with chronic pneumonitis quoted statistics as follows: "In 1941, 679 cases collected from existing literature of which 367 were attributed to neoplasm, 222 to congenital abnormalities, 41 to infection and 40 to trauma." Levine further emphasizes the need to include the esophagram as an integral part of the examination. She also states that aspiration of organic material into the tracheobronchial tree may go on for years with minimal stress to the patient. Madore and Blay,[11] reporting a case of esophagobronchial fistula complicating an esophageal diverticulum in a 53-year-old male, indicate the primary presenting symptom as massive bleeding by mouth. This coincides with the same primary symptom in the case reported here. Other authors[13, 15] in reporting similar cases indicate that syphilis and histoplasmosis as well as tuberculosis may be an underlying cause of fistula tract formation. Hutchins and Lindskog[8] report on such a case of fistula with histoplasmosis as the etiological agent. It should be pointed out that in the case reported here, the tuberculin skin test as well as histoplasmin were reported negative. Furthermore, there was no comment in the histological report of the tissue removed of changes to suggest either tuberculosis or histoplasmosis and it must be concluded that a chronic nonspecific inflammatory process was the underlying cause.

The Treatment of Choice

Surgical correction of defect is the treatment of choice. Barrett[1] concurs with the importance of surgical correction in these cases and relates that typical symptoms especially hemorrhage should alert the clinician and that the esophagram confirms the diagnosis. Coleman and Bunch[3] in 1950, suggested the following overall classification for broncho-tracheo-esophageal fistulas based on etiology:

I. Congenital
II. Acquired
 A. Malignant
 B. Nonmalignant
 (1). Traumatic
 (a). Foreign Body

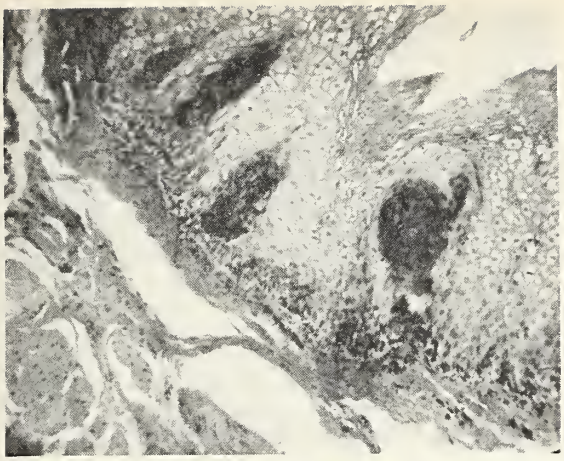


Figure 8. Histological appearance of surgical specimen showing both bronchial and esophageal components.

(b). Instrumentation
(c). Wounds of thorax
(d). Chemical ingestion of caustics
(2). Esophageal diverticulum
(3). Infection
(a). Tuberculosis
(b). Syphilis
(c). Fungus
(d). Nonspecific

Summary and Conclusion

A case of spontaneous bronchoesophageal fistula associated with a traction diverticulum in the esophagus in a university student is reported. A review of the literature confirms the rarity of the entity when unrelated to trauma or neoplasm. The need for performing an esophagram to establish the diagnosis is stressed. The importance, therefore, for investigating both the bronchial tree as well as the esophagus in all cases of hemoptysis with undetermined cause is discussed. The literature along with the reported case indicates the value of surgical correction as the treatment of choice with low mortality and high cure rate.

Acknowledgment

The authors wish to express their gratitude to Orville S. Walters, M.D., Director of Health Services and McKinley Hospital, Urbana, Illinois, for granting permission to publish this case.

References

1. Barrett, F. A. Bronchoesophageal fistula—case report. *Rocky Mt. Med. J.*, Feb. 1958, 49-51.
2. Clagett, O. T., Payne, J. H., Moersch, H. J. Acquired esophagotracheobronchial fistula. *Surg. Gynec., and Obst.*, Jan. 1946, 87-89.
3. Coleman, F. P. and Bunch, Jr., G. H. Acquired nonmalignant esophagotracheobronchial fistula. *J. Thoracic Surg.*, April 1950, 19, 542-556.
4. Das, J. B., Dodge, O. F. and Fawcett, A. W. Intralobar sequestration of lung associated with foregut diverticulum (esophagobronchial fistula) and an aberrant artery. *British J. Surg.*, May 1959, 46, 582-586.
5. Davis, E. W. and Katz, S. Broncholithiasis, a neglected cause of bronchoesophageal fistula. *J.A.M.A.*, Feb. 1956, 160, 555-557.
6. Duprez, A., Wittek, F. and Dumont, A. Acquired and congenital esophagobronchial fistulas, *Thorax*, Sept. 1956, 11, 249-256.
7. Hewitson, R. P. Non-malignant esophagobronchial fistula in the adult. *South African Med. J.*, July 1961, 35, 533-536.
8. Hutchin, P. and Lindskog, G. E. Acquired esophagobronchial fistula of infectious origin. *Jr. Thoracic and Cardiovas. Surg.*, July 1964, 4, 1-12.
9. Kovarik, S. L. Palliative treatment of a bronchoesophageal fistula. *J. Thoracic Cardiovas. Surg.*, August 1963, 6, 252-255.
10. Levine, I. Chronic pneumonitis secondary to nonmalignant bronchoesophageal fistula. *J.A.M.A.*, March 1953, 151, 995-997.
11. Madore, P. and Clay, A. Esophagobronchial fistula complicating esophageal diverticulum. *Canad. M. A. S.*, Oct. 1958, 79, 564-566.
12. Mellins, R. B. Acquired fistula between esophagus and respiratory tract. *New Engl. Jr. of Med.*, June, 1952, 246, 896-901.
13. Miller, G. E. Bronchoesophageal fistula associated with esophageal diverticulum. *Canad. J. Surg.*, April 1961, 317-320,
14. Minkari, T. Benign transpulmonary esophagobronchial fistula associated with a traction diverticulum. *J. International Coll. Surg.*, Oct. 1963, 40, 393-399.
15. Paul, L. W. and Juhl, J. H. *Essentials of Roentgen Interpretation*, Paul B. Hoeber Book Company, New York, 1959, pp. 361-362.
16. Shope, R. E. and Petersdorf, R. G. Mediastinal tuberculosis manifested by pericarditis, osteochondritis and bronchoesophageal fistula. *American Review of Tuberculosis and Pulm. Dis.*, Feb. 1959, 2, 238-243.
17. Stephenson, H. E., Jr., Wolter, J. H., Burkeholder, J. N. Spontaneous esophagobronchial fistula formation surgically treated in a 90 year old woman. *Missouri Med.*, Aug. 1961, 826-828.
18. Stewart, W. R., Klassen, K. P. and Horoua, A. P. Esophagobronchial fistula due to esophageal traction diverticulum. *Archieves of Surg.*, Feb. 1958, 76, 317-321.
19. Westerheide, R. L. An unusual complication of a bronchogenic cyst. *J. Thoracic and Cardiovas. Surg.*, March 1964, 389-393.

THE PREDICAMENT OF THE AGED

Eric C. Kast, M.D./chicago

ANY REFLECTIVE DISCUSSION about a topic of such import as old age may well begin with a certain self-examination exploring the attitude of the observer to the given topic. It is difficult for the observer to call the people involved "old people." One attempts to substitute elderly, senior, etc., for "old." This reluctance can be found not only in the literature but also in daily conversation and in the lay press, as well as in the self-description of old people. If one finds that attribute attached to a person it is almost always with a negative connotation. Yet other attributes referring to age are not so endowed. "Young" is a compliment in almost every sense. "Middle-aged" already has some of the stigma of the attribute "old." This fact reflects the real attitude and meaning of the problem of the old person. If not an outright insult, it is certainly a derogation to be called old or to consider oneself old. It is a misfortune to be old, and a blessing to be young. It implies that one has been used, contaminated; that the newness, the virgin purity, has been taken out, and now one is old, wrinkled, slightly dirty, and ready for the junk heap. That is the picture, the concept which we have of old people and old people, consequently, have of themselves. That is the self-image we all place in the eyes of septuagenarians and that is the source not only of depression and other psychic difficulties but also of organic diseases and precipitous death.

Much of geriatric science today is infected with this dilemma. The managerial and custodial phase of geriatrics, especially, struggles with this ambivalence. Should we deny the existence of old age and make "oldsters" or "senior citizens" or "elderly" out of old people, or should we state the obvious, and call those who fall within a certain developmental age "old"? The mentioned ambivalence, as all ambivalences, is given to over-compensations on either side. We shall try to avoid this in the present paper.

In order to appreciate the special significance and intricacies of the dilemma of older people, we first have to obtain a clear picture of what the behavior and motivations of an older person are like. Let us then assume him to be relatively free from disabling disease. Let us observe a person in his middle seventies with mild generalized arteriosclerotic changes, mild hypertrophic arthritis, a bit hard of hearing and with a slight impairment of vision due to cataracts. He has just recovered from the effects of a transurethral resection for benign prostatic hypertrophy. He is able to

get about, has a well-adjusted family and he is reasonably satisfied with the life he is leading.

As we watch him walking down the street we notice limited muscular excursions; the movements are halted and guarded; he swings his arms in a restricted fashion and his gaze is downcast, as though watching the road for obstacles. He is a bit shorter than he was in his prime and there is a certain unmistakable constriction in his demeanor. We approach him now and find that his field of interest is not very wide; he does not generate any particular enthusiasm about any specific area of inquiry. He shows some interest only in that which concerns him or his immediate surroundings and problems. He likes to reminisce and brings forth and repeats stereotyped ideas which he has been bringing forth for the past number of years and which, at one time, brought him some acclaim. He is concerned with the realities and technicalities of life and not with the broader scope; as a matter of fact he will recoil from abstract or theoretical topics. Then, with a twinkle in his eye and with pride in his voice, he will ask you, "guess how old I am," and when your guess falls short of his actual age he will triumphantly state that he is much older than you thought. The overall impression we gain from him, however, is that of a mild depression with an overcast of fear and reluctance. This mild depression may make its appearance either in inhibited and hesitant behavior or in a certain pseudo-exuberance: appearing not to care and to wish to exhaust all the pleasurable experiences life can offer before the door closes. These characteristics, in general, represent old age at its best.

The Fear of Isolation

Now, this somewhat uncharitable image painted for you of an old person has as its basis certain cultural and biologic changes and their mutual interrelationships. There are certain related fundamental and undeniable phenomena accompanying old age: the imminence of death and a certain cultural and personal isolation. We all, young and old, are concerned with immediate and imminent death. It is commonplace to state that death can happen to anybody, anytime. I doubt that the increased statistical likelihood of a sudden exit occurring in old age makes any particularly incisive impression on human beings. Excessive or inappropriate anticipation of death is really usually a manifestation of fear of inability and social impotence. However, one is led to assume that in old age this fear of imminent, disabling catastrophe is more marked than in youth. Partially, of course, it is based on realistic considerations, but partially it reflects the fear which is so frequently seen among older people, namely, the fear of isolation. This fear of isolation makes itself felt in the mild, above-mentioned depression which is really an expression of the wish not to lose contact, not be abandoned. Also, it is the basis for a certain ubiquitous hypochondriasis in older people, especially when partially deprived or faced with the potential deprivation of loss of hearing or sight, both very important means of contact. It is easy to see how this dreaded isolation may become a serious problem in aging.

The Response of Society

Now, how does society respond to this urgent need for contact? This, of course, differs among various civilizations. Our Western civilization is concerned with independence, competence and individualism, and does not view kindly a person who seeks a dependent and reassuring environment. The greatest reassurance against abandonment and isolation is respect. In spite of certain statements to the contrary, old age, in our civilization, does not inspire respect. The condescension and disdain usually shown to older people, especially those with some infirmity, act in feedback fashion to emphasize, for old persons, isolation and despair. Symptoms of this feedback are the above-mentioned phenomena of restrictions in movement and the downward gaze, society's interpretation of older people, and the impact of the interpretation on the individual. A downcast look and restricted movement may speak of introspection, of an inner life of great depth and profundity.

In some Eastern cultures, this behavior is so interpreted. Old people receive great respect and are viewed as men of great wisdom. Our Western society responds quite differently to these behavioral characteristics. Thus the social impact on the old person is different and in consequence his self-image is one of what society sees him to be, a tottering fool. In an attempt to recapture the dignity so sorely needed by older people, they become querulous and managerial. They become repetitious, insisting on certain trivia which in turn emphasizes their so-called incompetence, evoking further condescension and disdain from their environment. The tenuous and transparent pride, previously mentioned, which the old person expresses in his achievement of advanced age, represents something he has done, which the younger people have not; and hence, the triumphant attitude when we could not even fathom how far advanced in age, and consequently superior and indestructible this older person really was.

Role-Playing of Old People

Role - playing is frequently observed among old people, and often the role is that of an old person. In that way a person can pretend to accept and recognize reality, by playing the role of an old person and otherwise maintain an unrealistic fantasy of youth, vigor and indestructibility. Like youngsters, old people when threatened by a loss of self-esteem assume alien roles, attitudes, or postures, hoping to regain, in that way, some of the lost self-respect. This role-playing serves a very important defensive purpose in maintaining ego structure and ego control. When this role-playing becomes threatened either due to external influences (uncooperativeness of the environment, cruelty) or inappropriateness of the role adopted, the whole ego structure may collapse and senile psychosis may develop.

So far, we have been concerned with a description of a so-called normal old person. We can use this image as a baseline for further deliberations about certain pathologies seen among old people. Space does not permit us to discuss many of the pathologies commonly encountered, and therefore I wish to limit myself to three target areas commonly affected in senescence.

Malignant Tumors

First, tumors, including malignant tumors, are seen at all ages, but by and large the incidence of cancerous disease is higher in late middle age and early senescence. This condition is dreaded by all older people and rightly so. Their good health of which they are so proud and which serves for them as a source of respect and self-esteem, becomes threatened. The false illusion of indestructibility is destroyed. The specter of inability and incompetence, accompanied by a need for total dependency, becomes greater. Consequently their feeling of isolation becomes accentuated and presents a collapse of defensive forces.

Malignant tumors usually occlude some orifice to add further emphasis to the dreaded isolation. Fear of choking, inability to swallow, or inability to urinate or defecate becomes a frightful symbol of the long-dreaded state of separation. Usually, an opening has to be made to alleviate this obstructed state and a tracheostomy or colostomy has to be performed. The depression seen very commonly following these procedures is due in part to the obvious tenuousness of such small openings as lifelines to the outside world. These small openings are carefully guarded by patients and panic ensues if even mild, incomplete obstruction threatens to obliterate these communication channels.

Usually, death comes gradually with malignant diseases. It is preceded by a long and protracted course of suffering, during which the relationship of the patient to his environment becomes structured. Usually, two opposite attitudes prevail and may coexist in the family of such afflicted persons; one is one of outright rejection. The patient is placed in a nursing home or hospital and only perfunctory visits are paid. The other attitude, which may be even more destructive, is one of solicitous love and self-sacrifice, qualities certainly unassailable from a social standpoint. However, this

solicitous and concerned handling may often be a defense mechanism on the part of the family to contain their rage and anger about the inconveniences and sacrifices imposed on them.

A peculiar phenomenon takes place in these chronically ill, suffering people. They become more and more concerned with the immediacy of the situation, dismissing, to a large extent, the longer range hopelessness and despair. Aside from surgical interventions, the use of radioactive substances and cytotoxic agents, the treatment of these conditions is primarily in the realm of social service. Psychotherapy has little to offer to these patients.

We might mention the use of lysergic acid diethylamide and other hallucinogenic agents in such situations. In our experience of about 250 cases, this agent is capable, in a high percentage of instances, of making these patients more aware of the moment and less of the dismal future awaiting them. The effect of this drug, sometimes lasting up to two weeks following one administration, is that the immediate sensory input assumes an overwhelming role in the sensory life of the patient. While he can verbalize and state, "yes, I am going to die"; "yes, I am desperately sick"; he may, at the same time, be occupied intensively with the reflection of an object, stating how beautiful this is and that he has never experienced such transcendental loveliness.

Vascular Diseases

The second group of diseases which usually affect old people are vascular diseases, either acutely occlusive, as in a stroke or myocardial infarct; or slowly obliterating blood vessels, as in kidney disease and peripheral vascular occlusive disease. The former are catastrophic diseases with a sudden onset and marked locomotor disability. While tumors are chronically debilitating diseases, cardiovascular catastrophes are more dramatic. There is little time for psychic elaboration and adjustment. The pale fear of acute catastrophe demands the attention of the moment and anticipation of events to follow is of subordinant nature. Patients in these situations muster amazing strength and determination to conquer illness. The evolution of such a cardiovascular catastrophe may be divided into two stages; one is the acute stage, during which the patient is usually hospitalized and receives much attention. Hypochondriasis and depressions are usually not seen in this phase. It is dominated by medical procedures and a certain euphoria caused by the mastery of such a catastrophe. The second phase, called rehabilitation, is slow and grinding. During this phase, depressive and hypochondriacal conditions make their appearance. All characteristics of old people, outlined initially in this presentation, become more marked and harder for the patient's environment to bear. Usually, a frank and open discussion of the diagnosis, prognosis and treatment of a given vascular catastrophe is in order. Obviously, danger cannot be denied but it can be minimized by emphasizing that everybody is in the same boat. Everybody is threatened by the possibility of immediate catastrophe. One can combat isolation by making those who are thus threatened into a cohesive group. One must remember that solicitousness and reassurance have no place in the treatment of depressive states.

The damage of an acute vascular catastrophe occurs usually in one of two target organs: the heart or the brain. These organs are considered to be the sites of life, thus making a fantasy loss or damage to such organs difficult to bear. Such loss may be associated symbolically with social impotence, inability, and isolation. Long-term therapeutic attempts such as anticoagulant therapy, vascular dilators and follow-up tests can be used as focusing agents to concentrate the patient's self-concern, hopefully leaving the remainder of the patient's activities free for more productive purposes.

Psycho-Social Disabilities

A third area of inquiry is the area of psycho-social disabilities and chronic brain syndrome. Chronic brain syndrome is often caused by cerebral arteriosclerosis. Patients with senile dementia, often associated with chronic brain syndrome, present only custodial problems. Their affective

life is greatly deprived; they are usually not depressed and rarely present other than managerial problems. Chronic brain syndrome, on the other hand, with depression, deserves further inquiry. The characteristics of aged behavior, namely depression, hypochondriasis and limitation of scope become more accentuated, creating a vicious cycle. As stated before, these characteristics are ill-received by our society, further aggravating the isolation they impose on the individual. The rejected patients then retreat into further hypochondriasis and depression because in that way their disability becomes structured and thus more accepted by their environment. Illness can be a face-saving device, because in our society, disability due to illness is much more acceptable than the stigma of old age. Above all, certain regressive features of old age are commonly disguised in hypochondriacally conceived illness.

Of course, there are other psycho-social phenomena accompanying old age which deserve mention. There exists a realistic dependency of older people on their environment. This dependency may be of financial character, may be due to limited motor activity, or may be a need for approval. This dependency usually is accepted by society either only grudgingly or not at all, resulting either in an increase of isolation or in the production of hypochondriacal symptoms. This represents an attempt to substitute a socially acceptable form of distress, namely illness, for a socially unacceptable one, namely the need for dependency.

Appropriate resolution and treatment of these very complicated problems are difficult. A few general guide lines may serve to direct thinking on these matters in constructive channels. Above all, an old person needs respect and the maintenance of positive life affirmation. Dignity and self-respect may serve to combat the inevitable feeling of isolation old people experience. Everybody concerned with issues of old age becomes aware of the difficulty encountered in integrating older people into a younger society. Older people *are* isolated and consequently should be treated as such. Denial of this isolation shows condescension, further detracting from the dignity of people. Therefore, communities of old people are being established all over the country. At the same time special values suitable for an aged community are established. In such "isolated" environments where the spiritual and physical standards are adapted to the requirements of old age and where the acceptance of old age is ubiquitous, new libidinal interest in existence may be created.

It is important to deal with the realistic appraisal of illness in all its aspects in open discussion. It adds to the dignity and to the self-respect of older people to inform them, without cruelty of course, about their diseases, outlook, and treatment. Such discussions express implicitly trust in the personality strength of the old person, and so add much to his dignity and stature. At times, even clear verbal acknowledgment of death or its imminence is in order. As mentioned before, the obvious parallel of the immediate danger in which we all find ourselves may serve as a tool to combat the isolation of the old, based on the fact that they are not singled out to die soon and be unable to participate in the stream of life.

Summary and Conclusions

An image of an old person has been presented, emphasizing his limitations and capabilities. Isolation and depression are the main characteristics of the physiologic aging process. Hypochondriasis can be used as a defense against isolation. The impact of malignant tumors, cardiovascular catastrophes and chronic brain syndrome on old people is discussed.

As a basic therapeutic guide line in dealing with old people, it is suggested that cognizance be taken of the realistic isolation of old people and that they be integrated within their own society with their own spiritual and physical standards. Furthermore, all attempts should be made to preserve the dignity and self-respect of old people. This can not be done through condescension or solicitude but through open and free discussion of the infirmities encountered and resolute measures taken.

TWO FOREIGN BODIES OF THE APPENDIX: A CASE REPORT

R. J. Maganini, M.D., F.A.C.S. and*
*Wayne Mathy, M.D.**/berwyn*

THE MEDICAL LITERATURE is replete with reports of foreign bodies of the veriform appendix. The list of artifacts found in appendiceal lumens is long and includes such items as: pins, needles, nails, pebbles, screws, gallstones, buttons, seeds, leadshot, pieces of bones, wood fragments, iron filings, beans, oat hulls, cherrystones, chestnuts, bristles, eggshell, hair, teeth, globules of solder, ascarids, pinworms and other helminths, fish vertebrae, fins, twigs, straw, nutshells, sunflower seeds, wire fragments, bits of oystershell, bullets (swallowed) and toothpicks[1,2,4,5].

These reports lend credence to tenets of folk-medicine and the admonitions of our grandmothers that warn of swallowed grape-seeds and similar ingested foreign bodies, which could "fall into your appendix" and possibly cause appendicitis. That this indeed can happen is well demonstrated in a case report by Fredell[4] in which acute appendicitis was caused by a pointed foreign body lodged in the appendix.

In view of the fact that pointed or sharp appendiceal foreign bodies have a greater tendency to cause mucosal irritation and even perforation[1,4] the presence of such a foreign body (or bodies) in the appendix even in the absence of symptoms constitutes an indication for prophylactic appendectomy.

Shpilko[3] and Chulanov et al.,[2] both reporting in the Russian literature, encountered lead birdshot (usually multiple) as the most common foreign body of the appendix. Most of these patients were from rural areas where the shooting and ingestion of gamebirds was widespread. Shpilko[3] reports one case in which 89 lead pellets were found in the appendix (incidental finding) at autopsy.

The authors recently encountered a case in which two asymptomatic foreign bodies of the appendix were found.

Report of a Case

An asymptomatic 39 year old white male grocer was examined in the office and an intravenous pyelogram was performed as a routine workup for hypertension. Two foreign bodies, a small wood screw and a single lead shot, were noticed in juxtaposition to each other in the right lower abdomen. Subsequent x-rays of the abdomen including barium enema (Figure 1) re-

*Senior Surgical Staff, MacNeal Memorial Hospital, Berwyn, and Courtesy Staff, Hinsdale Sanitarium and Hospital. **Department of Internal Medicine, MacNeal Memorial Hospital.



Figure 1: X-rays of barium enema examination showing appendiceal foreign bodies.

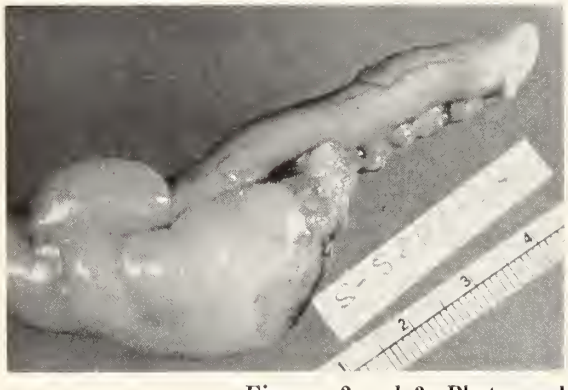
vealed these two metallic artifacts to be in the lumen of the appendix. This patient could not give a history of accidental ingestion of any foreign bodies; however, he had eaten wild pheasant on more than one occasion, which could explain the presence of the lead shot. The patient had no symptoms referrable to the gastrointestinal tract. Because of the presence of a pointed foreign body (the screw) in the appendix, the patient was advised to have an appendectomy as prophylaxis against possible appendiceal perforation or appendicitis. This patient underwent appendectomy on November 12, 1964 and had an uneventful postoperative course. Examination of the appendix following surgery revealed the presence of the wood screw as anticipated (Figures 2 and 3) ; however, the lead shot was no longer in the appendiceal lumen. It is thought that the catharsis and irritation incident to barium enema and preoperative surgical preparation were factors in causing the lead shot to pass into the cecum and thus out of the gastrointestinal tract. A postoperative x-ray of the abdomen revealed no evidence of the lead shot.

Summary

A case of the authors' is presented in which two metallic foreign bodies of the appendix were found in a 39 year old white male grocer, who had no symptoms referrable to the gastrointestinal tract. Prophylactic appendectomy was advised and performed, because one of the artifacts was a (pointed) wood screw. On the basis of the experience of other authors[1,4] this type of foreign body (pointed) would be most likely to cause appendiceal perforation or irritation. The experience of Shpilko[3] and Chulanov et al.,[2] shows that hunters and other persons who ingest wild game birds may be candidates for foreign bodies of the appendix (lead birdshot).

References

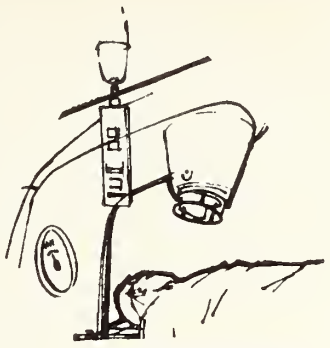
1. Friedman, M. H. and Mackenzie, W. C.; A Foreign Body In the Appendix: A Report Of An Unusual Case. *Canadian Journal of Surgery*, Vol. 3:98 (October, 1959).
2. Chulanov, B. I. and Lifshits, E. M.; Foreign Bodies of the Appendix. *Klin. Med. Moskva*, Vol. 39:142 (June, 1962) (Russian).
3. Shpilko, V. N.; Foreign Bodies of The Appendix. *Khirurgia Moskva*, Vol. 35:104-106 (December, 1959) (Russian).
4. Fredell, C. H.; Appendicitis In An Infant Due To An Ingested Foreign Body. *Archives of Surgery*. Vol. 88:209 (February, 1964).
5. Collins, D. C.; A Study of 50,000 Specimens of The Human Veriform Appendix. *S. G. & O.* Vol. 101:437-445 (1955).





Figures 2 and 3: Photographs of the pathologic specimen.

Medical Progress



HARVEY KRAVITZ M.D./progress editor

LIVER FUNCTIONS IN CLINICAL MEDICINE

ONE OF TWO PARTS

Frederick Steigmann, M.D./chicago

In the diagnosis, treatment and prognosis of liver disease the results of liver function tests are utilized, although practical experience has shown that they frequently do not clearly mirror what actually is going on in the liver. The latter was attributed earlier to the fact that the so-called liver function tests were at best only insensitive indicators of liver function in that marked damage to the liver cell had to occur before these tests become abnormal. The newer and supposedly more sensitive tests, particularly the various enzyme tests which form the so-called "enzyme profile" which have recently been introduced also failed to correlate closely with the structural changes. The lack of correlation has been noted both under the light microscope and the electron microscope.

Despite the above discouraging note the clinician is nevertheless helped in his diagnosis of a jaundiced patient by the results of a group of hepatic tests which can be performed, at present, in most clinical laboratories. It must be stressed that in the cases of jaundice the liver function tests are of more value if done early in the course of the disease inasmuch as secondary changes in the liver may occur after prolonged jaundice which will modify the results of the tests. Moreover, it has to be kept in mind that the clinical laboratory performing these tests must be reliable since incorrect data are more dangerous than none.

The clinician who interprets the so-called liver function tests should be aware of their limitations and should be familiar with their physiologic basis. He should know that many of them don't actually measure the normal physiologic activities

The Hektoen Institute for Medical Research, and the Department of Gastroenterology, Cook County Hospital; the Department of Medicine, University of Illinois College of Medicine, Chicago, Illinois.

of the liver, that others indicate only the presence of some pathologic process within the liver rather than impaired function, and that only few of the chemical changes are pathognomonic of liver disease. This awareness will lead to the realization that no single test is capable of either diagnosing liver disease or differentiating between so-called medical (hepatocellular) and surgical (extrahepatic obstructive) jaundice. Hence, for elucidation of pathologic changes in the liver or differentiation of the type of jaundice a battery of tests—or profiles—has come into use.

For this discussion the presently used liver function tests in a large general hospital were selected. These include tests which have been tried for a long time, which have proven reliable within the discussed limitations and which can be carried out in any adequately staffed and equipped clinical laboratory; they also include some more recently introduced tests some of which are still not in general use but which seem to have a promise for the future.

The so-called liver function tests can be arranged according to the matter or activity which they are supposed to measure. Accordingly, they will be discussed whenever possible in the boundaries of such groupings. Although urinalysis, as a rule, is not considered a liver function test the presence or absence of urinary bile pigment is of great importance and therefore will be discussed.

Pigment Metabolism: Endogenous

1. *Serum Pigment*—bilirubin. Normally the serum contains less than 0.3 mg. of direct (1 minute) and 1.3 mg. of total bilirubin — end product of hemoglobin breakdown—per 100 ml. This amount of bilirubin gives an icterus index of 6 to 8 units.

In jaundice due to hepatocellular damage or to biliary tract obstruction—regurgitation jaundice—the total bilirubin may rise to 2 or 3 mg. percent before the jaundice appears manifest while in hemolytic jaundice (retention jaundice) it may rise to even higher levels before icterus is evident.

In regurgitation jaundice, the direct reacting bilirubin constitutes 25 to 75 percent of the total. In hemolytic jaundice it is usually below 20 percent. The ratio of direct to total bilirubin may thus distinguish between hemolytic and regurgitation jaundice, but not between hepatic, or extrahepatic—obstructive jaundice. In some cases of mild hepatitis, however, the direct to total ratio may be lower than that obtained in patients with severe hemolytic jaundice in whom a hepatocellular component is superimposed. In such instances the direct to total ratio may not be a reliable one for the differential diagnosis of jaundice. It should, however, be emphasized that in hemolytic jaundice the direct bilirubin rises only proportionately to the total bilirubin so that the ratio tends to remain in the approximate 20 per cent range. In hepatocellular disease, however, there may be an increase in the direct fraction without simultaneous rise in the total bilirubin.

Determination of the bilirubin level is of diagnostic value in detecting latent jaundice. Serial tests for the bilirubin level are of prognostic value by eliciting changes and fluctuations in the intensity of the jaundice which the eye cannot perceive. Thus in many instances of convalescing hepatitis the patient's bilirubin level may have decreased markedly but the patient may still appear quite jaundiced due to the fact that his skin has been deeply stained. The bilirubin level drops more precipitously after release of an extrahepatic obstruction than on improvement in a case of hepatitis.

2. *Urinary Pigment.* Normally the urine does not contain bilirubin but may contain traces of urobilinogen. In hemolytic or retention jaundice there is an increased amount of urobilinogen in the urine but no bilirubin (acholuric jaundice).

Bilirubin appears in the urine only in the so-called regurgitation jaundice, i.e., jaundice in which bilirubin B or bilirubin glucuronate which has passed through the liver cells is regurgitated from the bile capillaries into the lymphatics and into the blood stream. The presence of a dark or choluric urine (like coca-cola) indicates regurgitation jaundice which may be due either to liver damage or to extrahepatic ob

	Highest Norms	*Medical*	*Surgical*
Urobilinogenuria	P	†*	0**
Bilirubinuria	0	†	†
Fecal Urobilinogen	P	†*	0**
Albumin	5.5	Low†	Normal
Globulin	3.4	High	Normal
Gamma Globulin	1.2	High	Normal to Low
Cholesterol	250	Normal—Low	High
Cholesterol Esters %	65	Low	Normal
Alkaline Phosphatase	4.0	Slightly Increased	High
Cephalin Flocculation	†	Two to Four Plus	Zero to One Plus
Thymol Turbidity	4	Increased	Slightly Increased
SGO Transaminase	40	High	Slightly Increased
SGP Transaminase	40	High	Slightly Increased
Prothrombin Time	100	Increased	Increased
Response to K		Little	Good
Icterus Index	8	High Rising	High Stable
Muco Proteins	120	Low—Normal	Increased††
SICD	250	High†††	Slightly Increased
SOCT	100	High	Slightly Increased
LDH	250	High	Slightly Increased
GUANASE	3	High†††	Slightly Increased

* Also Present Intermittently in Incomplete Obstruction (Surgical Jaundice).
** Also Absent in Intrahepatic Cholestasis (Medical Jaundice).
† May Be Low in Advanced Malignant Disease With Extrahepatic Obstruction.
†† Especially If Associated With Neoplasm.
††† Striking Difference Between Medical and Surgical Jaundice in the Acute Stage.
P Present.

struction. In severe regurgitation jaundice of either type bilirubin may be absent from the urine if renal failure co-exists. In the defervescent stage of hepatitis or after relief of extrahepatic obstruction, bilirubin may disappear from the urine while the serum bilirubin level is still elevated and while the urobilinogen in the urine is still increased.

In intrahepatic cholestasis none or little urobilinogen is found in the urine but much bilirubin, and the patient appears therefore, like a case of extrahepatic obstructive jaundice, including clay colored stools despite the fact that there is no extrahepatic obstruction.

Urinary urobilinogen is usually found increased in hepatitis, cirrhosis, in intermittent or incomplete hepatic cholestasis, in hepatic carcinoma, fatty liver, infectious mononucleosis, congestive heart failure and in various conditions associated with hemolysis, fever or septicemia. Urobilinogen is absent or found in only low values in extrahepatic and intrahepatic cholestasis, in hepatic diseases associated with anemia, and hepatic disease complicated by renal failure. Urobilinogen is absent in the newborn infant because there are no bacteria entering the colon. In severe diarrhea, urobilinogen may be absent because the bilirubin has not remained in the intestine long enough to be transformed into urobilinogen and then absorbed via the porto-hepatic circulation. Urobilinogen may disappear from the urine of patients receiving broad spectrum antibiotics because antimicrobial therapy alters the intestinal flora which changes bilirubin to urobilinogen.

In some instances of acute hepatitis the initially elevated urobilinogen may disappear completely during the stage of cholestasis, only to reappear and to rise to high levels again, during the recovery period. Curves drawn from the results of the daily

determinations of bilirubin and urobilinogen in such cases cross each other twice. The first crossing occurs when the bilirubin rises and the urobilinogen drops during the early stages of the disease and the second crossing occurs during the defervescent stage when the urobilinogen rises and the bilirubin drops. The first crossing signifies a serious stage with guarded prognosis, while the second one indicates recovery.

The tests for urobilinogen and bilirubin in the urine are very simple, and should be done daily on the freshly voided urine of a patient with jaundice until a definitive diagnosis has been made and while the patient is still in the "workup" or observation stage since changes in the amounts of either pigment have prognostic value, too. If the urine contains much bilirubin this interferes with the determination of urobilinogen so that it is important to precipitate out the bilirubin by adding calcium chloride or barium sulfate to the urine and then testing the filtrate.

3. *Fecal Pigment.* Normally an adult excretes between 40 and 300 mg. of urobilinogen in the feces per day. In children the values are lower. On high fat diets fecal urobilinogen is increased possibly because of increased hemolysis from fatty acids.

In hepatitis and cirrhosis as well as in incomplete obstruction resulting from stones, the values vary between 10 and 300 mg. per day. In instances of severe hepatitis the values of fecal urobilinogen are low —around 10 mg.—because little bilirubin reaches the intestine, since most of it regurgitates through the areas of damaged liver cells. In malignant extrahepatic obstruction, which is usually complete, the values vary between zero and 10 mg. per day. After antibiotic therapy less than 5 mg. per day may be excreted. In hemolytic anemias the values vary between 300 mg. and 1800 mg. per day and during hemolytic crises the excretion may rise to over 2000 to 3000 mg. per day. Quantitative daily determinations of urobilinogen excretion in the urine and feces can be expressed as a ratio which is helpful in the diagnosis of liver damage and hemolysis. The ratio between fecal and urinary urobilinogen is higher than normal in hemolytic states, than in liver disease, in which there may be marked urobilinogenuria with low to average fecal urobilinogen. In liver disease plus cholestasis the values of urobilinogen in both the urine and feces are low.

In extrahepatic obstructive jaundice of the complete type the stools are acholic because no urobilinogen—or only a few milligrams (up to 10.0)—are present in the feces, due to the fact that no bile enters the intestinal tract. The little urobilinogen found is thought to be derived from the bilirubin in the intestinal cells which are daily given off.

Pigment Metabolism: Exogenous

Bromsulphalein.—Of the dye excretion tests the bromsulphalein is most commonly used, although it is being performed mostly in liver disease without jaundice. When bromsulphalein is injected intravenously most of the dye is taken up by the liver cells and excreted into the bile. The rate of disappearance of bromsulphalein from the blood depends on the excretory capacity of the liver, the patency of the bile ducts and the hepatic blood flow.

The uptake by the hepatic cells depends not only on their functional capacity but also on the efficiency of circulation. Exercise, standing, and fever increase the bromsulphalein retention, while its clearance is enhanced after a meal persumably because of increased hepatic blood flow. The influence of circulation upon hepatic bromsulphalein uptake permits its use in the estimation of hepatic blood flow, or splenic blood flow, by measuring the hepatic extraction by hepatic vein catheterization. Bromsulphalein is less toxic than most other dyes but reactions are seen occasionally which apparently are anaphilactoid in nature. This occurs especially if serial tests are performed. The reaction may be avoided by giving the injection slowly. Thrombophlebitis may occur at the site of the injection of the dye if the latter infiltrates the tissues.

Five mgs. of bromsulphalein per kilogram of body weight is usually used and the excretion determined after 45 minutes. In normal persons the retention varies between zero and 6 per cent. The test can be used in children.

In hepatitis, cirrhosis and biliary obstruction, abnormal results are found with great regularity. Bromsulphalein retention is found in cirrhosis without jaundice, carcinoma, fatty liver, in congestive heart failure, fever, malaria, infection, shock and gallbladder disease. Bromsulphalein retention is also increased in anicteric hepatitis. It is slightly increased in mild jaundice, of intermittent incomplete extrahepatic cholestasis while it is more markedly increased in hepatocellular diseases with the same degree of jaundice. The bromsulphalein retention is increased in thyrotoxicosis and diabetes mellitus. Its increase in cases with hepatomegaly associated with an increase in the alkaline phosphatase points to a space occupying lesion. In hepatic failure the bromsulphalein retention is abnormal because of the poor hepatic circulation.

After a dose of 2 mg. of bromsulphalein per kilogram has been given the bromsulphalein appears in the duodenal fluid usually within 15 minutes. In the first two hours, 50 to 85% is excreted in the bile and most of the rest appears within the next two hours. The excretion of bromsulphalein in the bile just lags somewhat behind blood clearance.

Normally none of the dye is lost in the urine but small amounts may be excreted when there is marked bromsulphalein retention or when albuminuria is present. The recirculation of bromsulphalein, if it occurs at all, is not a significant factor in the rate of dye clearance from the blood. In the absence of jaundice and circulation disturbance, the degree of dye retention is usually proportional to the extent of liver cell damage.

Protein Metabolism

Plasma Proteins. Because liver damage is often associated with variable changes in the composition of plasma proteins, their determination in patients with jaundice may be of diagnostic and prognostic help. Normally the total serum proteins are between 6 and 8 grams per 100 ml., of which the albumin fraction represents normally 3.5 to 5 while the globulin 2.5 to 3 grams percent. The albumin including the alpha globulin (0.8 to 1.1 grams per cent) is formed by the hepatic cells, while the globulin is formed by the reticulo-endothelial system. The alpha globulins are low in hepatic failure; high in injury or infection. The serum albumin is usually decreased in instances of hepatocellular damage, especially the chronic type. It is a relatively insensitive test of liver function, but may occasionally be a guide in following the progress of liver disease and jaundice. A rising level, e.g. in patients with cirrhosis, is a good sign.

The globulin rises in hepatocellular disease, both in the acute and chronic type. This is due mainly to the increase of gamma globulin which normally is 0.6 to 1.25 grams but which may rise to nearly 2 grams percent in acute and to 2 to 3 grams in chronic liver disease. The highest levels of gamma globulin are found in postnecrotic cirrhosis, myeloma and in diseases associated with reticulo-endothelial system proliferation, chronic infections and hyperimmune reactions. Gamma globulin is low or decreased in obstructive jaundice and lymphoma.

Another globulin fraction is the beta-globulin which is normally 0.9 to 1.2 grams percent. The lipoproteins migrate with the beta-globulins. The latter are increased in cholestasis, especially in Xanthomatous biliary cirrhosis, but are decreased in nutritional cirrhosis. Occasionally, the globulin fractions may rise, as determined electrophoretically, while the total globulin is still within the normal range. It is important to keep in mind that a rise in gamma globulin is not diagnostic of liver disease since it may be associated also with a variety of conditions affecting the reticulo-endothelial system.

The total protein is usually lower than normal in hepatic diseases. However, occasionally because of a marked rise in the

globulin a picture of hyperproteinemia may present itself. In liver disease or in patients with jaundice it is therefore important to know the values of the albumin and globulin and not only of the total protein.

The albumin/globulin ratio is often reversed in chronic liver disease due to the above mentioned reasons.

Plasma Prothrombin. The plasma prothrombin level may be considered a true liver function test since the synthesis of prothrombin occurs in the liver. In the presence of vitamin K a low prothrombin level means deficient synthesis and hence a poor liver function. Since in patients with jaundice there may be a low plasma prothrombin level due to either deficient synthesis or failure to absorb vitamin K because of absence of bile in the intestinal tract, the injection of vitamin K should lead to restitution of a normal prothrombin level in patients whose jaundice is obstructive, extrahepatic, but not in those in whom jaundice is due to hepatocellular damage. This supposition has proven itself diagnostically of value in only limited instances since other plasma proteins, fibrinogen, accelerator globulin (factor V) and convertin (factor VII) which also concern themselves with blood coagulation may be deficient too, but these are not measured by the prothrombin time test. Clinically, however, one finds that if a patient has severe hepatocellular disease the administration of vitamin K in large doses will not cause a rise in the level of prothrombin, but, indeed, at times there may actually be a decrease in the prothrombin following large doses of vitamin K. However, if the patient has an extrahepatic obstruction, then the administration of vitamin K will result in an increase of the prothrombin to the hundred percent level and will remain there for 24 to 48 hours. Accordingly, one might say that response of the prothrombin to an injected dose of vitamin K indicates good liver function while little or no response indicates severe hepatic damage. The prothrombin time is usually found reduced in cirrhosis whether with or without jaundice, in prolonged cholestasis, in hepatitis, in external biliary fistulas and in prolonged toxic hepatitis. In any form of hepatic disease there is usually a decreased prothrombin time. Our findings have been that in most of the chronic cirrhosis patients prothrombin is deficient and does not respond very well to vitamin K.

The prothrombin may also be reduced in chronic gastrointestinal disorders especially if enteric antibacterial drugs are given. After the administration of vitamin K in hepatitis cases, slight rise of the prothrombin after 24 hours and a drop after 48 hours indicates an abnormal response, as is also a gradual ascent after 24 to 48 hours. We measure the prothrombin time by the one stage method.

Serum Mucoprotein. The serum mucoprotein determination has been used by us only in recent years. The serum mucoproteins are carbohydrate protein complexes, mainly components of the alpha-1 globulin fractions. The serum contains normally, 80 to 130 mg. of mucoproteins per hundred ml. They are reduced when alpha globulin is low, as in severe hepatic failure, severe hepatitis and postnecrotic cirrhosis. In acute infections complicating hepatic insufficiency the mucoproteins increase simultaneously with the alpha globulin rise. The serum mucoproteins are often elevated in biliary obstruction and regularly elevated in secondary hepatic carcinoma and in chronic infections. The serum mucoproteins aid in the differentiation of primary hepatic diseases from hepatic tumor metastases or biliary obstruction. A rise of the mucoprotein level in cases of cirrhosis may suggest the development of a malignancy.

Flocculation Tests. These tests are being used as part of the liver profile although they do not mirror hepatic function but rather express alterations from the normal in the serum proteins. They may corroborate the presence of hepatocellular damage but don't measure any specific function of liver cell. They reflect mostly quantitative or qualitative changes in gamma globulin and serum albumin.

The cephalin flocculation test (Normal = 0 to 1+) determines the stability of a

cephalin cholesterol emulsion following dilution in serum. Increased amounts of gamma globulin reduce the stability whereas albumin and alpha globulin stabilize against flocculation.

The flocculation depends not only on quantitative albumin-globulin changes but also on the qualitative changes or reduction of alpha globulin. The cephalin cholesterol flocculation is abnormal early in liver disease. In hepatitis the cephalin cholesterol flocculation is positive in a high percentage of patients; it is slightly positive in anicteric patients and in intrahepatic cholestasis and toxic hepatitis.

It is strongly positive in active cirrhosis, but may be negative in cirrhosis without jaundice and in extrahepatic obstructive jaundice and in fatty liver without jaundice. In these latter it may become positive if infection supervenes. The cephalin cholesterol flocculation may be positive in tumors of the liver and in infectious mononucleosis. While the cephalin cholesterol flocculation test is of value in confirming liver cell damage and thus in the differential diagnosis between medical and surgical jaundice, it is often unreliable because it remains abnormal for long periods when the patient is apparently recovered. Hence, it is not a good guide to follow the progress of the hepatitis. Moreover, extrahepatic infection affects the cephalin cholesterol flocculation to some degree so that errors in interpretation may occur.

The thymol turbidity (Normal = 1 to 4 units) depends on the turbidity formed by the dilution of serum with a barbital buffered thymol solution, the protein precipitate being mainly gamma globulin with some beta globulin. This reaction is affected by the pH and ionic strength.

An increase in gamma globulin, beta lipoproteins and serum lipids increases the turbidity. Albumin stabilizes this reaction more by its quality than quantity. Hence, in hepatitis, there is less stabilization.

The depression factor in cholestasis decreases the thymol turbidity. Ether extraction of the serum lipids, heparin, and tumors decrease the turbidity. Elevation of the serum lipids increases thymol turbidity, so that an increased thymol turbidity after high fat intake can serve as a fat absorption test. The thymol turbidity is increased in acute hepatitis because of serum lipids alteration; in chronic hepatitis more because of gamma globulin changes.

The thymol turbidity is markedly increased in infectious hepatitis, especially the A type; it is slightly elevated in toxic hepatitis, in intrahepatic cholestasis, in fatty liver and in nutritional alcoholic cirrhosis, even if jaundice is present. It is, however, markedly increased in postnecrotic cirrhosis, and this makes the thymol turbidity a useful test for differentiating the types of cirrhosis. The thymol turbidity is only slightly increased in extrahepatic obstruction. It may rise more if secondary infection or hepatic damage occurs, but to a lesser degree than the cholesterol cephalin flocculation. It may also be slightly increased in infectious mononucleosis, lupus erythematosus, rheumatic arthritis and similar chronic inflammatory diseases. A persistently high thymol turbidity following hepatitis points to a poor prognosis, indicates a smoldering disease.

The results of cephalin cholesterol flocculation and the thymol turbidity overlap frequently, but they still show sufficient differences to warrant their use simultaneously, in a liver profile. The thymol turbidity differentiates better between medical and surgical jaundice and the different types of cirrhosis. The cephalin cholesterol test detects cirrhosis better and is not affected by increases in lipids in the serum.

Part II, the conclusion of this article, will appear in the March 1966 issue of IMJ.

CONTROL OF GASTRIC HEMORRHAGE WITH GASTRIC HYPOTHERMIA

George S. Schwerin, M.D./chicago

IN THE MARCH 1963 issue of the *Illinois Medical Journal* an article reported the successful control of massive gastric hemorrhage in a patient with gastric ulcer, through the use of a closed system of gastric cooling. Accepted therapy for this condition was applied and when the expected results failed to appear, the attending physician utilized the gastric hypothermia technique developed by Dr. O. H. Wangensteen and his associates at the University of Minnesota in 1962. Many reports of the successful application of the technique have since been published, and four more cases with unusual overtones are presented as a follow-up to the original case report.

Case Number 1

On April 16, 1963 an emaciated, 80 lb., pale 70-year-old white woman with cyanotic lips was admitted to Jackson Park Hospital with a diagnosis of upper gastrointestinal hemorrhage of thirty hours duration and a history of chronic rheumatoid arthritis with marked deformity and limited ambulation. The patient complained of black, tarry stool on the previous day and again on the day of admission, plus two episodes of vomiting copious amounts of old blood that left her weak, dizzy and sweating. She further stated she was feeling well until the present time, except for a flareup of her arthritis for which she would take aspirin for relief.

On physical examination, the patient was alert. Blood pressure was 111/60 and temperature, pulse and respiration were within normal limits. The abdomen was readily palpable because of the patient's thin condition, but no abnormalities were found. There were traces of old blood around and in the mouth and the black, tarry stool was strongly positive for blood. BUN and FBS were normal; Hb 8.2 grams and Hmct. 28%. A tentative diagnosis of silent, bleeding ulcer was made; RO gastric ulcer or carcinoma of the stomach.

A naso-gastric tube to suction gave a return of fresh blood with occasional blood clots and blood-stained mucus. The tube was alternated hourly with a Murphy drip of chilled skim milk. Additional treatment consisted of one unit of whole blood, antacids, anticholingerics and intravenous estrogens. The vital signs remained in normal range throughout the night and by 7:00 a.m. the naso-gastric tube return showed only an occasional fleck of fresh blood clot. At this time the laboratory findings were Hb 9.9 gms and Hmct. 31%.

About midafternoon gastric suction return began to show an increase in fresh blood and by 5:00 p.m. fresh blood comprised nearly the total return from the

stomach. It was agreed that the patient was a poor surgical risk due to the uncontrolled hemorrhage as well as her poor physical condition. It was further agreed that gastric cooling might be a helpful measure to effect control. The patient was subsequently transferred to St. James Hospital in Chicago Heights where a gastric hypothermia unit was available.

Hypothermia Started

The patient was admitted to the hypothermia room with vital signs in normal range and fresh blood readily aspirated through the naso-gastric tube. Patient cooperation was excellent throughout the preparatory procedures of pharyngeal topical anesthesia, ice water lavage of the stomach through an Ewald tube and the swallowing of the folded gastric balloon. The balloon was inflated with 400 cc of alcohol coolant from the gastric hypothermia machine (Swenko) which was circulated at a fairly constant range of 5 C. for five and a half hours. Fresh blood was returned through the naso-gastric tube washings in diminishing amounts for the first 45 minutes and thereafter the washings were free of any evidence of bleeding. During the cooling treatment there were no abnormal alterations in blood pressure, respirations, pulse or temperature, the latter being controlled by using a "K" Thermia mattress and a Thermistor rectal probe. The patient was given one unit of whole blood intravenously.

Following deflation and removal of the gastric balloon, the patient was restarted on a Murphy drip of skim milk plus antacids, anticholingerics and, later, an additional dose of estrogenic hormone intravenously.

On the morning of April 18, the blood picture was Hb 8 gms and Hmct 26% with vital signs remaining within normal limits. There was no sign of hemorrhage returned in the gastric washings. That evening, with the clinical finding unchanged, the Murphy drip was discontinued and the patient placed on an acute ulcer milk diet. Gastric washings taken the following evening returned mucus streaked with fresh blood (rebound phenomena?) and continued to show this hemorrhage sign until mid-morning. The hemoglobin and hematocrit were 6 gms and 19% respectively.

There was no further evidence of bleeding from the naso-gastric tube from this point on, and on April 21, with the patient remaining fully compensated and the Hb and Hmct essentially unchanged she was given two units of whole blood over a 12-hour span and the next morning one unit of packed cells. This restored the reading to Hb 13.6 gms and Hmct 39% and they remained within normal range thereafter.

An April 23 x-ray report of the stomach showed: prominent ampulla; gastric ulcer in the fundus of the stomach (the radiolucency around this raising the possibility that the latter was a malignancy with a central ulceration); no delay in emptying time; and duodenal ulcer.

A further diagnostic work-up included normal urine, two-meter chest film and an EKG. An eight-hour gastric juice specimen was negative for free Hcl and repeat cytological studies of gastric washings were negative for malignant cells.

It was concurred that the total weight of evidence of malignancy was great enough to warrant surgery and on May 1 a sub-total gastrectomy was performed. Recovery was uneventful and the patient was discharged in a limited ambulatory state on May 11.

The pathology report of the gastric specimen read in part: "Segment of stomach, including narrow segment of duodenum, with changes constant with healed ulcer of the duodenum."

At the present time, the patient has made a weight gain of four pounds on a six-small-meals-a-day diet schedule and is fully restored to her pre-hemorrhage limited ambulatory state, except for medical management of mild cardiac decompensation which developed six months after surgery. She maintains a cheerful and optimistic attitude.

Comment

This case presents several opportunities for discussion, including bleeding "silent ulcer" and classical diagnostic "red her-

rings" which are familiar to the profession, but comment will be confined to the patient's weight relative to the gastric cooling, plus blood loss and replacement with the patient remaining compensated throughout two hemorrhagic episodes.

The rapidity of gaining control of the gastric hemorrhage in 45 minutes was probably directly related to the small weight volume of the patient, allowing a faster dissemination of lowered temperatures through the stomach walls and the subsequent constriction of the vascular plexus. A "cold spot" was felt over the left epigastrum within 15 to 20 minutes after the onset of the cooling technique, attesting to the quick dispersion of the colder temperature since, under ordinary circumstances, this spot is not noticeable for two to three hours in patients with normal weight and moderate abdominal fat tissue layer. Prolonged gastric cooling leads to a lowering of the body temperature in proportion to the patient's weight, duration of cooling and the temperature level of the gastric balloon coolant. In this patient, rapid heat loss was countered by the use of the automatic rectal probe, which controlled the heat level in the thermal mattress. The patient's lack of insulating fat tissue allowed the ready absorption of heat over a large surface of her body from the mattress and subsequently there was no shivering nor was there any deviation from normal body temperature range.

Blood Replacement

Changes in clinical vital signs along with dermal alterations and patient response are accepted indices for gauging hemorrhage rate and volume, but in this patient no such changes were observed and only the laboratory reports provided a measure of the blood loss or increase. A comparison of laboratory blood reports prior to hospital transfer and those reports following cooling and administering one unit of whole blood indicate that the patient may have exsanguinated to levels lower than Hb 6 gms and Hmct 19% without signs of decompensation. The blood reports recorded after transfusion of two units of whole blood and one of packed cells show a hemoglobin gain greater than 2 gms per unit transfused, not considering the volume of a packed cell unit is much less than that of a whole blood unit. Packed cells were prescribed to avoid a possible hypervolemia and subsequent chance of a new hemorrhage, taking cognizance of the patient's sub-normal weight. Blood replacement was finished at a normal range with less than three units of whole blood.

Case Number 2

A white male, 63 years of age, was treated for Laennec's cirrhosis, hepatic decompensation with encephalopathy, left hydrothorax and non-specific viral pericarditis. The patient had a history of abdominal aortic graft for anuerysm in 1957, sub-total gastrectomy for perforation and hemorrhage of duodenal ulcer in 1958 and portocaval shunt for relief of advanced cirrhosis in December 1962.

On April 21, 1963 the patient was admitted to the gastric hypothermia room of St. James Hospital accompanied by the attending physician who had responded to an urgent house call because of the patient's sudden vomiting of massive quantities of blood. Diagnosis and critical condition of the patient had been given via telephone by the attending physician, enabling the hospital to have personnel and apparatus ready for immediate application.

On arrival the patient was semi-comatose and jaundiced. Also present were distended abdomen, cold, moist skin, pitting edema of the legs and large quantities of blood pooled over his face, chest, bed clothes and bath towels. Blood pressure was unobtainable and the pulse was fast, thready and uncountable. Diagnosis was given as shock from massive gastric hemorrhage secondary to ruptured esophageal varices from advanced terminal Laennec's cirrhosis.

Without patient cooperation and no application of topical anesthesia to the pharyngeal area, an Ewald tube was inserted into the stomach and lavage with ice

water removed many large clots as well as fresh blood. A naso-gastric tube with suction was placed within the stomach prior to removal of the Ewald tube and this was used as a guide for the insertion and placement of an eosophageal balloon and its co-axial tubing attached to the cooling machine. The patient did not gag or manifest any resistance to the manipulations of the various tubes used in preparation for cooling, but did on occasion open his eyes momentarily in response to questions or commands.

Hypothermia Process

The eosophageal balloon was inflated with 400 cc of alcohol solution and this coolant was circulated in a temperature range of two to four degrees C. and maintained for an hour and 45 minutes. The tamponade effect of the eosophageal balloon combined with the local cooling caused a diminishing of blood content in the return washings within 15 minutes and after 30 minutes of cooling there was no further evidence of active bleeding. However, on two occasions, the patient in his stuporous dementia suddenly tried to pull the balloon from his stomach, exerting enough stretch on the balloon to bring into view the attachment section to the co-axial tube. Cuff restraints were applied and the patient showed no apparent gastro-eosophageal damage or return of hemorrhage from this pronounced tugging. During the cooling process the blood pressure and pulse made a gradual recovery so that when cooling was terminated these clinical findings were BP 130/90 and pulse 100/minute. A unit of whole blood had been started, followed by two more units after the patient was placed in his room. On the morning of April 22, the laboratory report showed Hb 11 gms and Hmct 31.5%.

About 27 hours after cooling, 12:30 a.m., April 23, the naso-gastric tube began to show evidence of recurrent hemorrhage which progressively increased in intensity until the patient's expiration at 3:00 a.m. No attempt was made to reapply gastric cooling for control of the terminal hemorrhage.

The autospy report showed the following: portal cirrhosis of liver with eosophageal varices, massive bleeding; marked, diffuse myocarditis; porto-caval anastomosis; gastro-enterostomy; generalized adhesive pericarditis; pulmonary emphysema; peritoneal fibrous adhesions; edema of legs; marked generalized arteriosclerosis; marked myocardial hypertrophy (450 gms); and benign intramural leiomyoma of the stomach.

Comment

The family had been informed of the terminal status of the patient and that successful application of the gastric cooling technique in this instance would only postpone a recurrence of a similar and fatal hemorrhage. Evaluation of the efficacy of gastric cooling for massive upper GI hemorrhage as applied in this case will be allowed to rest on the principle of "res ipse loquitor."

Case Number 3

On May 5, 1964 a 58-year-old male was admitted to St. James Hospital with a history of chronic duodenal ulcer and recent upper GI bleeding with melena. X-ray studies indicated a duodenal ulcer plus gastric lesion and the patient was given two units of whole blood while being prepared for surgery. A laparotomy done on May 11 disclosed an extensively metastasized inoperable cancer of the lesser curvature of the stomach. Postoperative recovery was uneventful and on May 25 the patient was given a dose of the antimetabolite 5FU in an attempt to slacken the extension of the neoplasm. However, that evening massive upper GI hemorrhage took place and 13 units of whole blood, plus other supportive treatment, was given over the next nine days in an effort to counter the continued hemorrhaging. On June 5 a gastric balloon was induced and subsequently inflated with 500 cc of alcohol solution. The gastric cooling was maintained for four hours with a temperature range of about 10 C. In one hour and 45 minutes the return washings from the naso-gastric tube demonstrated no evidence of hemorrhage; however, cooling was continued for two additional hours to help assure post-cooling control.

In this application of gastric cooling, as in the preceding two cases, a thermal mattress automatically controlled by a rectal probe and thermistor was used to counter the general lowering of body temperature caused by sustained visceral cooling. Similarly, there was no sign of shivering. The post-cooling management was also the same as in the first case.

During the course of recovery in the next nine days the patient was given two units of packed RBC's, which elevated the hemoglobin and hematocrit. About 26 hours after the gastric cooling there was a short, uneventful period of recurrent upper GI bleeding in an otherwise relatively progressive convalescence. At the time of discharge, the patient was on a bland diet and complained of being hungry. He died from the effects of the metastatic neoplasm in a Veterans Administration hospital four months later.

Comment

This case is unique in that it demonstrates effective control of an iatrogenically induced upper GI hemorrhage from an extensive gastric cancer. How much adverse influence the antimetabolite was still exerting at the time of the gastric cooling was not ascertainable, but with the increasing use of these palliatives in the treatment of carcinoma of the stomach, a greater incidence of gastric hemorrhage from this source may be anticipated.

Case Number 4

On October 27, 1964 a well-developed, 180 lb., 54-year-old white male was admitted to St. James Hospital because of a subphrenic abscess, probably secondary to ruptured viscus from peptic ulcer or carcinoma. A sub-costal incision and drainage were done on November 9, releasing about 5000 cc of foul, purulent liquid. The wound was closed with drains for continued release of the suppurative fluid which cultured Alpha Hemolytic Streptococcus.

About 9:00 a.m. on the first postoperative day, the patient developed signs of shock accompanied by large amounts of melena. Thirteen units of whole blood were transfused in the next 12 hours in an attempt to counter a massive upper GI hemorrhage. During this period renal shut-down took place and the rectal temperature rose to 108.4 degrees F. The laboratory reported BUN 66 with impaired liver function.

Hypothermia Process

At 10:00 p.m. the patient was brought to the gastric hypothermia room in a state of moderate shock with BP 84/60, pulse 150/min., Hmct 17%. Two units of whole blood were being transfused through "cut-downs" in the left forearm and right leg. There was about 30 cc of urine in a plastic bag draining from a Foley catheter in the patient's bladder. Fresh blood comprised the total return from a naso-gastric tube under suction. The patient was indifferent to his condition but weakly responsive to commands. His upper abdomen was wrapped with post-surgical dressings showing a small amount of drainage stains.

The patient was given topical pharyngeal anesthesia and the stomach lavaged with ice water through an Ewald tube which returned only water deeply stained with fresh blood in the washings. Swallowing of the folded gastric balloon was accomplished without difficulty and the balloon was cautiously inflated with 600 cc of coolant at 5 C. No counter heating of the patient was applied for two hours in a successful effort to bring the patient's temperature down to normal and thereafter the automatic thermistor controls kept the rectal temperature at an average of 100 degrees F. for the next 34 hours. Within 45 minutes of the onset of cooling, the patient became more lucid and alert. His BP had risen to 146/84 with the pulse leveled to 120/min. During the 36 hour cooling period these vital signs averaged BP 134/70 and pulse 100/min.

Fresh blood with a small amount of mucus comprised the return in the naso-gastric tube for the first 12 hours of cooling and a reverse proportion of these elements made up the main return over the second 12 hours. In the last 12 hour period, the gastric return was black blood and clots

mixed with mucus and there were short intervals in which clear mucus was the sole return, showing that the hemorrhage was stopped or almost totally controlled. Also renal function returned to normal output during the initial 12 hours, producing over 1000 cc of urine during this period and output was normal thereafter.

When the patient was first brought to the gastric hypothermia room with two units of whole blood being transfused, three-fourths of one unit had been administered and completed in a half hour. However, the second unit was discarded because of clotting when only one-third transfused. Subsequently, two units of packed cells and one unit of whole blood were transfused during the first 24 hours of gastric cooling. About one hour prior to the patient's transfer to surgery, the laboratory reported hemoglobin 9.1 gms and hematocrit 24.5% and a second unit of whole blood was started and continued during surgery.

An exploratory laparotomy on November 12 showed the stomach to have a whitish, ischemic appearance that became more pale pink with clear reddish color to its small blood vessels by the time of closure. A perforation, 1 by 1.5 cm was disclosed in the first portion of the duodenum and no evidence of active bleeding was seen during the surgical procedure. A pyloroplasty and gastroenterostomy was completed and the patient moved to the recovery room. Four days postoperative, the patient was making a relatively good recovery.

Comment

In this application of gastric cooling for control of massive upper GI hemorrhage, a secondary benefit was the lowering of general body temperature to reduce the high fever arising from the combination of a septic state, renal shut-down, exsanguination and dehydration. This benefit became apparent quite early in the procedure with the return of renal function, the patient's improved sense of well being and the return of vital signs to normal levels, although there was not an appreciable amount of hemorrhage control at this time.

Discussion

In this presentation of four cases of uncontrolled upper GI hemorrhage arising from different clinical causes, the use of the closed system of gastric hypothermia proved effective in the control of the hemorrhage in each of these cases. Complications in each instance had classified them as poor risks for surgical intervention to control the gastric bleeding.

"Rebound" bleeding commonly occurs following the use of short term open perfusion or lavage of the stomach with iced water for checking upper GI hemorrhage and it usually becomes manifest within an hour after the treatment is stopped. In the four cases reviewed, a return of the hemorrhage was noted about 24 to 36 hours post-cooling in three of them and is somewhat analogous to the rebound bleeding in the open lavage system. Some investigators have noted transient hyperemia and edema of the stomach succeeding gastric rewarming after prolonged cooling. This may have been a contributing factor in the delayed return of hemorrhage in these three cases. In two of the cases, rebound hemorrhage was treated conservatively with satisfactory results apparent within a few hours. In each instance the recurrent bleeding did not approach the proportions encountered in the original episodes of hemorrhage.

Summary

Four patients with uncontrolled gastric hemorrhage arising from separate clinical causes and complicated with unusual clinical entities were effectively brought under control with use of the H. O. Wangensteen closed system of gastric hypothermia. Comments on heat exchange in proportion to body weight, blood loss and replacement, gastric hemorrhage following antimetabolite therapy, rebound bleeding and reduction of fever were noted.

References

1. Wangensteen, O. H., et al: Studies of local cooling as related to peptic ulcer. *Ann. Surg.* 150:346, 1959.
2. Walker, S., et al: Gastric cooling in treatment of bleeding from eosophageal varices. *Lancet* II:328, Aug. 1964.
3. Swan, H.: Clinical applications of hypothermia. Annual Clin. Conf. Chgo. Med. Soc. *CMS Bul.* 65: Sept. 1962.

4. Schwerin, G.: Control of gastric hemorrhage with gastric hypothermia. *Ill. Med. J.* 123:252, March 1963.
5. Nicoloff, D. M., et al: Local gastric hypothermia in the management of massive gastrointestinal hemorrhage. *Surg. Gynecol. Obstet.* 114:495, April 1962.
6. Wangensteen, S. L.: Intragastric cooling for upper gastrointestinal hemorrhage. *Surg. Clin. N. Amer.* 42:1171, Oct. 1962.
7. Sengstaken, R. W. and Blakemore, A. H.: Balloon tamponage for control of hemorrhage from esophageal varices. *Ann. Surg.* 131:781, May 1950.
8. Wangensteen, O. H., et al: Depression of gastric secretion and digestion by gastric hypothermia: its clinical use in massive hematemesis. *Surgery* 44:265, 1958.
9. McIlrath, D. C., et al: Gastric freezing: an experimental study. *Gastroenterology* 45:374, Sept. 1963.
10. Heimburger, I., et al: Influence of general hypothermia and local gastric cooling on portal blood flow. *Surgery* 47:534, April 1960.
11. Wangensteen, S. L., et al: Physiologic effects of gastric hypothermia. I. Effect on estimated hepatic blood flow in the normal anesthetized dog. *Surgery* 50:651, 1961.
12. Read, A. E., et al: Bleeding oesophageal varices treated by oesophageal compression tube. *Brit. Med. J.* (5168):227, 23 Jan 1960.
13. Turner, G. R., et al: Local gastric hypothermia in management of massive upper gastrointestinal hemorrhage. *Surgery* 53:609, May 1963.
14. Griffin, W. O., Jr. et al: Alterations in functions of stomach by local hypothermia. *Fec. Proc.* 19:188, 1960.

THE ETHICAL BASIS OF SCIENCE

Those who distrust science as a guide to conduct, whether individual or social, seem to overlook its pragmatic nature, or perhaps they scorn it for that very reason. Rightly understood, science can point out to us only probabilities of varying degrees of certainty. So, of course, do our eyes and ears and so does our reason. What science can do for us that otherwise we may be too blind or self-willed to recognize is to help us see that what is right enough for an individual may be wrong for him as a member of a social group, such as a family; that what is right for the family may be wrong for the nation; and that what is right for the nation may be wrong for the great brotherhood of man. Nor should one stop at that point. Man as a species is a member—only one of many members—of a terrestrial community and an even greater totality of life upon earth. Ultimately what is right for man is what is right for the entire community of life on earth. If he wrecks that community, he destroys his own livelihood. In this sense, coexistence is not only necessary but also right and science can reveal to us the best ways to harbor our resources and to exploit our opportunities wisely. *Science*, December 3, 1965.

AN EFFECTIVE AGENT AGAINST FUNGUS

Amphotericin B is the only currently available agent that is effective against a wide variety of systemic fungus infections. It is usually administered intravenously. Side effects are frequent and include fever, anemia, nephrotoxicity, renal calcification and hypokalemia. Therefore, treatment should be undertaken only when a firm diagnosis and appropriate arrangements for prolonged hospitalization have been made. Intrathecal administration is indicated in cases of cryptococcal meningitis that do not respond to intravenous therapy. Radiculitis, arachnoiditis and headache are common complications when this route is used. Bayard S. Tynes, M.D. The Clinical Use of Amphotericin B. *GP* (September) 1965.

TREATMENT OF HYPERTENSION IN PREGNANCY

John W. Pollard, M.D. and
Thomas R. Wilson, M.D./urbana

HYPERTENSION AND PREGNANCY are common conditions and frequently coexist in the same patient. Hypertension complicating pregnancy is associated with an increased morbidity and mortality for both mother and fetus. Thus treating a pregnant woman with an elevated blood pressure is a common and important problem.

Elevation of blood pressure during pregnancy can be due to pre-existing hypertensive vascular disease, toxemia of pregnancy, or a combination of these. If the blood pressure is elevated before the twentieth week of pregnancy, it is generally due to pre-existing hypertension. If elevated for the first time after the twentieth week it is due to toxemia of pregnancy.

Among patients with pre-existing hypertensive vascular disease there are a small percentage with hypertension due to correctible lesions. These lesions include coarctation of the aorta, pheochromocytoma, aldosterone secreting tumors, unilateral renal vascular disease and pyelonephritis. The screening of pregnant patients with pre-existing hypertension for these correctible lesions includes palpation of the femoral arteries, questions regarding episodic alteration of blood pressure prior to pregnancy, evaluation of serum potassium, auscultation for renal bruits, and obtaining urinalyses and urine cultures. If blood pressure remains elevated after pregnancy or if blood pressure cannot be controlled during pregnancy, additional steps to exclude correctible lesions are in order. Eighty-five to ninety percent of the patients with previous hypertension fall into the category of essential hypertension; that is, no cause for the elevation in blood pressure can be determined.

No matter what the cause of the hypertension, the blood pressure should be controlled. Antihypertensive medications are the means used in practically all pregnant women with elevated blood pressure. These medications are thiazides, hydralazine, alpha methyl dopa, guanethidine and rauwolfia alkaloids.

A thiazide diuretic is the first drug started and often the only one needed for control of hypertension. Blood pressure is significantly and persistently lowered in over 50% of the patients taking it and side effects seldom occur. These drugs promote sodium excretion and prevent the development of edema and generalized vasoconstriction. Actions of other antihypertensive agents are enhanced. The suggested daily dose is equivalent to 500 mg. twice a day of chlorothiazide (Diuril). There is no advantage of one thiazide over another.

The principal side effects of these drugs are due to low serum potassium. This results in hypo-kalemic nephropathy and myopathy. Also, patients who are hypo-kalemic are especially susceptible to digitalis toxicity. These complications can be prevented by the use of supplemental potassium in patients taking thiazides. Recent reports suggest the potassium supplements combined with thiazides are responsible for the circumferential stenosing ulcers of the jejunum and ileum seen in a small number of patients.

Other side effects of thiazide therapy in-

clude elevation of urea, elevation of uric acid, gouty arthritis, increased severity of existing diabetes mellitus and pancreatitis. These occur infrequently and subside when medication is discontinued. If gouty arthritis is produced, it can be treated in the usual manner.

Hydralazine (Apresoline) is added if the thiazide is not sufficient for control of blood pressure. This drug has a greater effect on diastolic than systolic pressure, and causes increased renal blood flow. Since hydralazine is metabolized in four to six hours, a q.i.d. dosage is recommended.

A syndrome resembling rheumatoid arthritis or lupus erythematosis may occur in patients receiving hydralazine. This has been reported with the use of as little as 100 mg. per day, but usually occurs in patients taking over 400 mg. per day. For this reason the maximum daily dose should not exceed 400 mg. This "hydralazine disease" is reversible if the drug is discontinued. Other side effects are palpitation, tachycardia, headache (particularly in patients with migraine headaches), myalgias, angina pectoris and congestive heart failure. These symptoms are lessened by starting hydralazine at a low dose and gradually increasing it and subside with continued use of the drug.

An Alternate Drug

Alpha methyl dopa (Aldomet) is an alternate drug which may be added if thiazides are not adequate for control of blood pressure. The recommended dose is 250 mg. three times a day with adjustment up or down as necessary. The maximum dose is two grams per day. Side effects of alpha methyl dopa are sedation and fatigue. These subside after two to three days of continued use. Rarely postural hypotension is a problem with this drug.

Guanethidine (Ismelin) is the "big gun" of antihypertensive therapy. It is added to other medications in patients with blood pressure elevation not controlled by the medications noted above. The proper dose is the amount necessary to restore blood pressure to normal. This varies from 10 to 400 mg. per day; most patients are controlled on less than 50 mg. per day. The usual starting daily dose is 10 mg. and increments of 10 mg. are made every third day until blood pressure control is achieved. The total daily dose can be given at one time.

Guanethidine blocks the sympathetics without affecting parasympathetic action; thus, many of the undesirable actions of ganglionic blockers are avoided. Orthostatic hypotension is the main side effect of guanethidine. This is a problem especially in the morning. A rare patient will lose consciousness from morning orthostatic hypotension during the dosage adjustment period. Hypotension may also occur with exercise. This is a problem for patients whose jobs require them to be physically active. Myocardial and cerebral infarction are potential dangers of hypotension in susceptible individuals. Other side effects are diarrhea and muscle fatigue. Parotitis and dependent edema are infrequently encountered side effects of this drug.

Rauwolfia Alkaloids

Rauwolfia alkaloids are discussed last, because I do not believe they should be used unless other methods of treatment are not satisfactory. This is a minority opinion, as many physicians use these drugs freely. My reason for suggesting limited use of rauwolfia products is that they cause depression in a high percentage of patients. The onset of the depression is subtle and often overlooked by both patient and physician. The other side effects are Parkinson's syndrome which subsides when the drug is discontinued, bradycardia, nasal stuffiness, diarrhea, nightmares, excessive sedation and increased appetite with weight gain. Except for depression these side effects present no significant problem.

Rauwolfia products do not manifest maximum action for two to three weeks and should not be abandoned as ineffective without a trial of about two months. Dosage equivalent to 0.25 mg. of reserpine twice a day is the maximum which should be used.

Using these drugs in an adequate treat-

ment program is the best means of preventing an hypertensive emergency. However, hypertensive emergencies do occur in a small percentage of patients in spite of satisfactory blood pressure control. Headache, confusion, somnolence, vomiting and convulsions are symptoms of the encephalopathy of hypertensive crisis. Prompt reduction of blood pressure is necessary. The drug of choice is reserpine given intramuscularly in doses of 2 to 10 mg. An effect can be noted in 30 minutes, but the maximal effect is not manifested for two to three hours. Intravenous reserpine acts no faster.

For greater speed of action a ganglionic blocking agent such as pentolinum tartrate (Ansolysin) can be used. Recommended dosage schedules are 5-50 mg. I. M., 5 mg. intravenously diluted in 20 cc. of saline, or 50-150 mg. per liter in a continuous drip. This drug can be used alone or until reserpine becomes effective. If prolonged treatment is necessary it can be alternated with reserpine. Sodium nitroprusside is another drug which can be used intravenously for control of hypertension in the emergency situation. Oral antihypertensive medications should be used as soon as it is feasible.

Two Cases

Two cases will illustrate some of the points we have made. The first case is that of an obese young lady with severe hypertension since 13 years of age. I followed this patient the year prior to her pregnancy and during that time excluded correctible causes of hypertension as best I could. Because of the young age of onset of hypertension I am still suspicious a correctible lesion is present. During the year prior to pregnancy the weight decreased from 230 to 205 pounds and blood pressure from 200 systolic and 130 diastolic to 140 systolic and 90 diastolic on thiazide, apresoline and ismelin. She responded to 25 mg. of ismelin initially, but needed 35 mg. in the last month of pregnancy. Dr. Wilson frightened this patient into reducing her basic weight 15 pounds more during pregnancy. Cesarean section was done because of a previous section. No complications were encountered in the treatment of the hypertension or in the obstetrical care. The blood pressure is now controlled on the same medications as before pregnancy.

The second case is that of a lady with mild hypertension controlled on rauwolfia before she became pregnant. The patient became depressed when she learned she was pregnant. Her reserpine was reduced to a total dose of 0.5 mg. from 1 mg. per day, and a thiazide was added. The patient did well until after her pregnancy. I stopped the reserpine after delivery, but restarted it when her blood pressure increased. When reserpine was restarted, the depression recurred. The patient is now doing well on alpha methyl dopa and thiazides. She is being evaluated to determine if a correctible lesion is causing her hypertension.

In summary then, we have reviewed the treatment of hypertension in pregnancy. Special emphasis was given to the use of antihypertensive medications. The treatment of hypertensive emergencies was discussed.

Discussion by Hugh C. Falls, M.D., Lake Forest

I would like to thank the society and Drs. Pollard and Wilson for the opportunity to discuss their interesting paper. The authors have clearly and concisely presented a logical approach to a problem made complex by the availability of a bewildering variety of antihypertensive drugs and an equally diverse assortment of opinions regarding their use.

I find very little to disagree with or add to the choice of medications or the proposed sequence in which they are used. Certain basic features of prenatal care in cases of hypertension complicating pregnancy probably go without saying, but I think should be mentioned anyway. I am referring to strict limitation of weight gain, a salt-poor diet, abundant amounts of rest, mild sedation and prenatal evaluation at intervals not longer than two weeks.

I would like to ask Dr. Pollard if he has had any experience with the combination of thiazide drugs and aldactone or dyrenium?

The spironolactone agents block the tubular resorption of sodium, but at the same time inhibit tubular excretion of potassium. In the opinion of some this potassium-sparing effect makes it an ideal supplement for thiazide derivatives in the protracted treatment of hypertension and/or edema. It may be particularly helpful in pregnancy because of the slight elevation in aldosterone and fluid retention which occurs normally. Avoidance of hypokalemia is especially important for the patient taking digitalis, either to treat or prevent congestive failure, as it may lead to digitalis intoxication.

The Question of Abortion

Several questions arise regarding the advisability of undertaking pregnancy in the presence of pre-existing sustained hypertensive vascular disease, and when, if ever, therapeutic abortion should be considered in the management of these problems. Before making judgment on these points one must assess the risk involved to the fetus and mother, assuming the patient has careful and adequate medical supervision throughout her pregnancy.

It is my impression that mild or medically well controlled essential hypertension is a relatively benign complication of pregnancy with little increase in fetal or maternal mortality and should not preclude future pregnancy. In addition there is increasing evidence that pregnancy per se, and even an episode of superimposed preeclampsia, does not accelerate the natural course of the disease. Such patients are more likely to develop preeclampsia, however, and when this complication supervenes, the hazard of fetal mortality is significantly increased and early delivery of the baby is indicated.

When a patient presents with severe sustained hypertensive disease with diastolic pressures consistently above 110 and evidence of reduced renal function, left heart strain and advanced retinopathy, subsequent pregnancy should be seriously discouraged. In this situation, in addition to a fetal wastage in excess of 50%, there is marked increase in the risk of serious complications for the mother. If there is definite evidence of renal insufficiency, congestive failure, or a rapid increase in blood pressure during the first half of pregnancy despite vigorous medical management, therapeutic abortion should receive serious consideration. The fetal mortality approaches 100% in these cases and there is a significant elevation in maternal mortality and morbidity.

When should a woman be delivered in a pregnancy complicated by hypertension? I believe that in mild or well controlled cases pregnancy may be permitted to go to term. These patients are prone to develop increased hypertension during labor and frequent blood pressure determinations should be obtained during parturition. Generally, the lethal or injurious fetal effects of placental ischemia will not occur unless there is a marked increase in blood pressure during the third trimester or a superimposed preeclampsia. It should be remembered that antihypertensive drugs may mask the presence of a concomitant preeclampsia; but that they do not prevent the harmful effects of the disease is evidenced by perinatal mortality rates similar to those in uncontrolled toxemia. When one of these complications appears, therefore, delivery at around 37 weeks gives the best chance for fetal survival.

The Problem of Hemorrhage

One more point is worthy of mention: Hypertensive patients are very vulnerable to the effects of blood loss and may lapse into deep shock sooner than anticipated if serious hemorrhage occurs. The explanation for this is probably that the adaptive mechanisms for sustaining blood pressure are disturbed as an inherent feature of the disease and further interfered with by medications. The point is that special efforts should be made to avoid hemorrhage and blood should be available for transfusion if needed. I know that a good deal of continuous caudal anesthesia is used at the Carle Clinic. I would like to ask the authors

if they feel that the existence of hypertensive vascular disease or the continuous use of such drugs as hydralazine, guanethidine, or diuril in any way disqualifies these patients from this form of anesthesia.

I should like to commend the authors for the emphasis they placed on the detection and removal of correctible lesions which account for 10-15% of hypertensive vascular disease. I also want to reiterate their conviction that control of the blood pressure during pregnancy is imperative if one is to avoid an unacceptable incidence of fetal or maternal damage.

Final Remarks by Dr. Pollard

Thank you for your discussion of our paper, Dr. Falls. Regarding your first question on the use of Aldactone or Dyrenium with thiazides, I must answer by saying we have not had sufficient experience with either of these drugs to comment on their effectiveness.

As you mentioned, caudal anesthesia is frequently used at Carle Clinic. We have found that neither the existence of hypertensive vascular disease nor the use of hypertensive agents has adversely affected patients receiving caudal anesthesia. Neither have we encountered difficulty with general anesthesia in patients on these drugs. I should emphasize that before any patient on a potent antihypertensive agent is anesthetized, the anesthesiologist is informed of the patient's basic problem and of the fact that she is on antihypertensive agents. I think this is particularly necessary when guanethidine is being used.

References

1. Dashe, Alfred M., Kert, Morley J., Mailman, Richard H., Roth, Samuel I., and Zager, Albert: A long-term study of combined guanethidine and hydrochlorothiazide therapy in the management of hypertension. *Angiology* 13:511-519, Nov., 1962.
2. Finnerty, Frank A., Jr.: The use of 1-hydrazinophthalazine (Apresoline) in the management of hypertension appearing early in pregnancy. *Amer. Jour. of the Med. Sciences*, p. 140, July, 1954.
3. Finnerty, Frank A., Jr.: Toxemias of pregnancy. *Med. Clinics of N. Amer.*, Vol. 45, No. 2, March, 1961.
4. Gifford, Ray W., Jr.: Hypertensive emergencies and their treatment. *Med. Clinics of N. Amer.*, Vol. 45, No. 2, March, 1961.
5. Goldberg, Leon I., Zimmerman, Alfred M.: Guanethidine and methyldopa as therapeutic agents in hypertension. A comparative review. *Postgrad. Med.* 33:548-54, June, 1963.

TRANSVESTISM

The most likely explanation of transvestism is that parents of homosexuals and/or tranvestites partially determine the behavior disorder by manipulating the sex role of their children. The manipulation may have arisen from a parental desire to have children of both sexes in the family of one sex children, or from a preference for all children of the same sex in mixed families. In our series, the youngest children in a family of boys, or boys in a mixed family with a dominant mother tended to become tranvestites.

Parents are also models for children as well as manipulators of them. As psychological and social models, parents provide images with which children may identify as they emerge from infancy into childhood and maturity. The process of identification first with the parent of the opposite sex, and then with the other is often a source of conflict. From our studies it would appear that many of our male transvestites did not overcome the transfer of identification in early childhood and proceed to identify with parents of the same sex. Further Observations and Comments on Transvestism, *New Zealand Med. J.:* 62:527-529 (November), 1963.

PREPARING A PAPER ON DRUG THERAPY: BASIC PRINCIPLES

Harold D. Kautz, M.D./north chicago

THIS ARTICLE IS OFFERED as an outline of basic principles to be followed in preparing a paper on drug therapy. It is intended as a general guide for the busy clinician who wishes to publish results of clinical studies on drugs.

Many articles dealing with the preparation of manuscripts for publication have been published, some of which are relatively recent.[1,2,3,4,5] Instructions to contributors of articles also are included in each issue of many professional periodicals, or can be obtained on request from the editors. Comprehensive guides covering all phases of writing and manuscript preparation are available in book or pamphlet from.[6,7,8,9,10] These are recommended for those who wish to make an elaborate study of writing methods.

Most available guides to medical writing are not oriented to any particular field. This suggests that there is a need for a guide specifically applicable to the preparation of articles on drug therapy. Such a guide conceivably may encourage more clincal investigators to publish results of drug studies. Many drug studies go unpublished, including those which are carried out in cooperation with pharmaceutical manufacturers to provide clinical case reports for the Food and Drug Administration. While all drug studies are not necessarily suitable for publication, reluctance to prepare a paper can arise because of the onerous task of writing. Though not to be undertaken lightly, the task of preparing an article for publication should not discourage the clinical investigator who is willing to devote a little extra time and effort.

There are good reasons why publication of the results of clinical drug studies should be considered more often than in the past. Advance planning for publication of a drug study tends to sharpen its design and improve the kinds of observations that are made. The effort of writing a paper also increases skill in exposition and organization of subject matter. Publication serves to document results of therapy and obviates the problematic use of references to unpublished data. Finally, publication offers the ideal medium for communicating the results of studies to others.

General Considerations

Most professional journals have certain general requirements for publication. One almost universal requirement is that *the material to be presented must not have been published or accepted for publication elsewhere.* Obviously most editors do not want to publish material that is not new or otherwise contributory. Duplication of articles also reduces the total space avilable for publication of new information. Specialty journals may require articles to be oriented to a particular field of medicine or surgery. On the other hand relatively new and suitably oriented material may not be acceptable if essentially the same subject has been covered recently by other articles already published in the same or another journal.

Manager, Product Information Department, Abbott Laboratories, Scientific Divisions, North Chicago, Illinois; formerly Secretary, Council on Drugs of the American Medical Association.

Conversely, editors may be willing to consider articles dealing with a previously studied drug if they offer some novel feature(s), i.e, larger series of cases, improved experimental design, previously unreported comparative observations (with placebo and/or other forms of treatment), use in different kinds of patients, trials in different diseases, etc.

Generally a paper on drug therapy is more likely to be accepted for publication if it deals with carefully controlled observations of a sufficient number of patients to afford comparisons between approximately equivalent groups. Moreover, reports on drug therapy should seek to provide some kind of answer to such fundamental questions as, "How many of the patients would have been cured (or improved) without the drug?"—"How many would have responded equally well to a previously established drug or other treatment?" Even uncontrolled studies of a new drug can be regarded as a contribution to medical knowledge when the results permit the reader to gain some perspective in relation to other forms of therapy. For instance, the results of drug therapy in a disease for which no effective treatment is available can be evaluated on the basis of known morbidity or mortality without the use of controls. In studies of new drugs for treatment of serious diseases in which a placebo should not be used, controlled comparisons can be made with an established drug or other method of treatment. An acceptable article also can be based on data to show that a new drug or dosage form, although not more effective, has other advantages, e.g., fewer or less severe side effects, more convenient route of administration, or unusual appeal for better patient cooperation.

Obviously the therapeutic effectiveness of a particular drug cannot be accurately evaluated if other drugs are given at the same time. Accordingly the use of drugs other than those which are being evaluated or compared, should be avoided. Aside from such standard needs as nutrition and fluid balance, drug studies should not include medications which are not being evaluated.

Whenever feasible, drug studies should be based upon objective measurements. Blood pressure determinations before and after treatment are essential in studies of antihypertensive agents; hemoglobin values are fundamental in studies on hematinics; cultures and other microbiological data are basic in the evaluation of antimicrobial drugs; etc. In diseases for which there are no objective tests, it is necessary to use a placebo and the blind method of study to eliminate conscious or unconscious bias. This applies to the subjective assessment of side effects as well as beneficial effects. Laboratory studies of blood, urine and tests for organ function also are essential for clinical evaluation of the relative safety and efficacy of new compounds or new uses of established drugs in different kinds of patients or diseases.

Outline of Presentation

A paper intended for publication always should be organized to follow a logical order of presentation. Comments relating to the title, authorship, and the introduction, are presented below with a discussion of the headings or sections commonly used. Alternative headings and the order of presentation may be modified when necessary to conform with the requirements of a particular journal and the subject matter.

Title, Author(s) and Source or Location of Study. Selection of a good title is important to attract readers who are interested in the subject and to insure that the article will be properly indexed for future reference. In drug studies it is desirable that the main title include the generic name of the drug(s) or the class of drug(s) tested and the name of the disease(s) or kind(s) of patients treated. A subtitle may be added, if desired, to convey further information regarding the nature of the study, for example:

(Main Title) METHYCLOTHIAZIDE IN THE TREATMENT OF CARDIAC EDEMA

(Subtitle) A Controlled Study of 50 Patients

In general the main title should not exceed 75 to 80 characters (letters, numbers and spaces). The main title example above totals 49.

The name(s) of the author(s) should include one complete given name and one initial plus the surname and principal academic degree, thus:

John B. Trout, M.D.
or
R. Paul Sloan, Jr., D.D.S.

Not more than six, and preferably no more than four authors' names should be shown; acknowledgment of technical assistance, if necessary, can be included as a footnote along with other acknowledgments.

The hospital, clinic or university affiliation of the author(s) where the study was done, should be shown on the title page. If present affiliation and location of the author(s) are different this also should be noted. If the paper has been presented at a public meeting, the name, place and exact date of the meeting should be indicated in a footnote or on the title page (see comments on length and style of manuscript).

Acknowledgment of the commercial source of supplies of drugs used should be footnoted and should indicate the trademark (if any) and the name of the manufacturer. This often can be done by use of an asterisk after the generic name, the first time this is used in the text, thus:

(Text) The drug, methyclothiazide,* was. . . .

(Footnote) *Methyclothiazide was supplied by Abbott Laboratories under the trademark Enduron®; or

*Methyclothiazide used in this study was supplied under the trademark Enduron® by Abbott Laboratories, North Chicago, Illinois.

If a commercial grant was involved, as well as drug supplies, such acknowledgment can be added to the footnote, thus:

This study was supported by a grant from Abbott Laboratories which also supplied methyclothiazide under the trademark Enduron®.

Grants from other sources should be separately acknowledged.

Introduction. The opening remarks at the beginning of a paper do not require a heading. They should be brief and express the reason for or purpose of the study. Citations of appropriate previously published articles on the same or related subjects are desirable when these will help to orient the reader and/or explain the need for obtaining additional information.

Authors should resist the temptation to present quotations or citations from a large number of previously published articles. Reference to one or two recent clinical reviews or three or four related clinical studies may be sufficient. When no previous studies of the same kind have been published, this fact should be stated. Results of previous similar studies should be cited when pertinent. Chemical and pharmacological data need not be included unless such information has not been published; references to published basic science reports can be cited when considered necessary. Each citation should be annotated consecutively as a superscript arabic number, thus: One observer[1] has reported similar findings. In a further report[2] these results were not confirmed, etc. When several references are cited together the annotated numbers should be separated by commas, thus:[1,2,3]. If a reference is cited more than once, its originally assigned number is repeated for each subsequent annotation in the text. The references cited are listed in numerical order at the end of the paper (see comments on references).

When the drug used in a study has a well established generic name it is usually unnecessary to include a systematic (complete) chemical designation or the structural formula. If there is no well established generic designation, the full chemical name should be stated parenthetically after the proposed generic name, if any, or alternatively after the investigational code number which has been applied to the compound. Most journals prefer that generic terminology (or the investigational code number) be used in the title and

throughout text of the paper; trade names, when applicable, should be shown only once, either parenthetically in the text, or as a footnote, the first time the generic, chemical or code designation is used in the text, thus:

(Text) The drug, methyclothiazide (Enduron®). . . . or use an asterisk after the generic designation and place the trademark in a footnote as noted previously.

Materials and Methods. This section of the paper may be alternatively designated as Design of the Study, Patients (Subjects) and Treatment Used, or other appropriate heading. It should be devoted exclusively to explaining the material(s) used and the method(s) of the study. The number of patients, age group (adult and/or children), sex, the diagnosis (or diagnoses), stage(s) of disease or condition, and status (outpatient or hospital), as may be pertinent to the study, should be clearly stated. If more than one treatment or control group was used, the number and kind of patients in each group should be indicated. Physical and laboratory examinations or other measurements which were used in evaluating therapy should be described. The dosage form(s) of the drug, placebo (if any), route(s) of administration used, the dosage(s) given, and the period(s) of treatment should be precisely stated for each group of patients studied. When subjective responses are evaluated the criteria used for judging changes should be indicated. Tables or charts can be used in this section to show the age, weight and sex of patients, the diagnoses, the criteria or tests applied, and the drug(s) employed, etc. However, if such tables or charts are to include results of the study, they should be presented in the next section.

Results. This section of the paper should present the results (positive and/or negative) which were obtained. It should include all significant observations which were made. The kind and frequency of side effects as well as therapeutic responses should be stated or tabulated. Statistical computations if used should be included in this section. Tables, graphs or other condensations are preferable to essay statements of the findings. Tables, charts or graphs should carry appropriate descriptive captions (titles) and should be simple and direct. Data presented clearly in this way need not be restated in the text. A table, chart or graph should be limited to not more than two or three variables. If several kinds of observations are involved it is best to present two or three separate tables rather than a single complex tabulation of results. Items which are tabulated should be precisely identified; explanatory legends should be included when necessary. (See comments on length and style of manuscript.)

In this section, citations of references or discussion of results of other studies generally should be avoided. Interpretive remarks or additional citations of related studies should be withheld for the next section.

Comment (or Discussion). Under this heading, the author(s) may offer interpretive comments regarding the results presented in the preceding section. Also it is here that personal opinions and clinical impressions may be expressed. Authors should beware of expressing opinions which are not supported by or are inconsistent with the reported results. Comments should be provided when necessary to clarify any unexpected or unusual aspects of the study. As noted for the introduction, this section of the paper should not be used to present a detailed review of the subject. Citations of other published studies should be limited to those that have specific interpretive application to the results which are being reported. Tentative conclusions or interpretations of the significance of the results should be included in this section unless these are considered sufficiently definitive to warrant a separate section (see below).

Conclusions. Clinical studies are seldom sufficiently precise to warrant definitive conclusions. Concluding remarks usually can best be added, without any heading, as a final paragraph of the preceding section, Comment (or Discussion). When a separate section is used to state conclusions they should be based directly upon the actual

results of the study. Definitive conclusions should not be drawn from clinical impressions. It is also important that concluding remarks (or specific conclusions if warranted) deal with negative as well as positive aspects of the study.

Summary. This section is a *must* and should be limited to not more than 100 to 150 words—perhaps, three to six sentences. It should set forth as succinctly as possible only what has been reported in the paper. It should not contain any additional facts or ideas not previously presented in the body of the article. One or two sentences can be used to paraphrase or restate the size and nature of the study, two or three sentences to summarize the results, and a final sentence or two to express the substance of the comment, impressions and/or conclusions. The sole purpose of a summary is to provide an accurate synopsis that will enable the quick reader to grasp the salient points of the article without reading it in its entirety.

References (or Bibliography). Customarily references are listed in the order of, and according to, consecutively assigned arabic numbers as these are cited in the text. Each reference should be given a different number and should be listed only once. Alphabetic arrangement (according to the last name of the first author) for numbering references is less desirable and is seldom employed except for comprehensive bibliographies in reference books or monographs. If alphabetized, first author arrangement is used for listing references; they are then numbered consecutively, and the appropriate numbers annotated in the text to correspond with the citations.

References to articles or reports published in periodicals should show the last name and the initials of all authors of the article, the abbreviated name of the journal, the title, the volume number, the number of the first page, the month (including date when applicable) and the year, in that order. Some journals require that references indicate the numbers of both the first and last pages of each article. Some also prefer that only the year of publication (not the month or date) be stated. Journal names should be abbreviated according to the Index Medicus. References to books should show the name(s) of the author(s), editor or translator, if any, the complete title (underscored), edition (beyond the first), city of publication, name of the publisher, year of publication and page(s) cited, in that order.

The following are ghost specimens of a journal and a book reference, respectively:

1. Trout, J. B. and Sloan, R. P., Jr., Treatment of Edema in Pregnancy, *Am. J. Med. Sci.*, 70:300, August 1965.

2. Cowling, H. O. (editor), *Symposium on Hypertensive Cardiovascular Diseases,* 3rd Edition, Boston, Little, Brown & Co., 1952, p. 217.

Length and Style of Manuscript

Clinical articles generally should be limited in length to not more than three to six journal pages (eight to fifteen double spaced typed pages of manuscript). Brief articles are generally preferred. A great deal can be reported in a short article if care is taken to avoid repetition by careful organization of the material. Each section of the paper should be complete so that it will not require further elaboration at some other place in the paper.

The manuscript should be typewritten, double-spaced (*including references*) on one side of medium weight white bond paper 8½ x 11 inches in size, leaving ample margins (1 to 1½ inches) at the sides, top and bottom of each sheet. It should have a separate, unnumbered title page (see comments on title, author(s) and source or location of study). The pages of the text should be numbered consecutively; references cited should be listed together at the end beginning at the top of a new page.

Charts, tables or graphs may be typed or drawn and inserted in the text if desired. When this is not feasible (as with photographs), they should be placed on separate sheets to accompany the manuscript. Usually a separate page is preferred for each table, chart or graph. When this is done, a parenthetic statement should be inserted in the text to indicate where each is to

appear in the paper, thus: (see Table 1); (Insert Figure 1); etc. Each chart, table or graph should be given its own number and a caption (title) to describe it. All abbreviations should be defined or explained by appropriate legends.

Before any manuscript is submitted to a journal, it should be carefully read and redrafted as necessary to achieve a presentation which reads clearly and is free from spelling or gross grammatical errors. Use simple words which carry the intended meaning; avoid complex words as well as medical jargon. Rely on a standard medical dictionary or other authoritative reference for selection and preferred spelling of terminology and abbreviations.

It is well to prepare two or more carbon copies of the finished manuscript. Some publications require an original and one carbon copy. Obviously the author(s) will wish to retain a copy for future reference.

When a manuscript is submitted, the date of submission and journal to which it is sent should be noted so that appropriate follow-up can be undertaken should the original manuscript become lost in transit or mislaid by the editorial office to which it was submitted. Don't expect an immediate reply. However, an acknowledgment should be forthcoming after a reasonable time. If the paper is not accepted by the journal to which it is first submitted, the explanation for rejection may provide a basis for making suitable changes, either for reconsideration or for submission to another journal.

References

1. Reeves, J. E., The Physician-Author, *Med. Times*, 90:1085, 1962.
2. Podolsky, E., The Doctor as a Creative Writer, *Southwest. Med.*, 43:476-479, 1962.
3. Gittins, J., A Guide to the Presentation of Papers for Publication, *Med. J. Austral.*, 2:632-634, 1963.
4. Roberts, A. L., (translator), Medical Writing, *J. Philippine Federation Private Med. Practitioners*, 12:665-669, 1963 (reprinted from *Therapeutic Notes*, Jan., 1963, Spanish edition).
5. Hartley, H. L., Manuscript Preparation, *Northwest Med.*, 63:35-38, 1964.
6. Roberts, F., *Good English for Medical Writers*, Springfield, Illinois, Charles C Thomas, 1960.
7. Zollinger, R. M., Pace, W. G., III and Kienzie, G. J., *Practical Outline for Preparing Medical Talks and Papers*, New York, Macmillan Company, 1961.
8. *Style Book and Editorial Manual*, 3rd Edition, Chicago, American Medical Association, 1965.
9. Southgate, M. T., Advice to Authors, *J.A.M.A.*, 190:113-136, 1964.
10. *Current Medical Terminology*, Chicago, American Medical Association, 1964.

(Note: A complete bibliography of sources of information on medical writing can be obtained from the American Medical Writers' Association, 2000 P Street, N.W., Washington, D. C. 20036. The last three publications listed above are separately available at nominal cost from the Division of Scientific Publications, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.)

THE BRIGHT FUTURE OF DRUG RESEARCH

Drugs of the future will be better tolerated by patients and will act with greater specificity. In the field of radiology, new agents will facilitate x-ray diagnostic procedures of the brain. Space medicine research promises to bring a beneficial fall-out of drugs for use in vestibular malfunctions, protection from harmful radiation, and reduction in fatigue. Other exotic areas of research may produce compounds that offer protection from extreme heat, and others from extreme cold. A pill that would repel insects is another possibility. The future of drug research was never brighter. The results will add to man's longevity, and will reduce the discomfort, suffering, and disability of disease. Austin Smith, M.D., *Emory University Quarterly* (21:-141), Summer 1965.

POLYNEUROPATHY DUE TO NITROFURANTOIN

Richard F. Herndon, M.D. and
Gerald E. Fox, M.D./springfield

NITROFURANTOIN IS WIDELY USED in the treatment of urinary infections. It has been limited by side effects of a gastrointestinal variety. Rare toxicity to the central nervous system has been described.[1-4] This paper presents a case of central nervous system toxicity with autopsy findings. One other case with post-mortem findings has been discovered in the literature[4]. Nitrofurazone (Furacin*) has been used systemically in the treatment of metastatic testicular carcinoma and has produced similar neurologic abnormalities. Another Nitrofuran, Furaltadone, has produced neurotoxicity[5,6]. The following case illustrates the neurotoxicity of Nitrofurantoin in extreme proportions.

Report of a Case

This patient was the only daughter of surviving healthy parents, born in 1908. In 1929 she had an appendectomy complicated by thrombophlebitis of her left leg. The following year she had pyelonephritis involving the left kidney. In 1931 she had a suspension of this kidney for proptosis. Subsequently a cyst of the right ovary was removed and in 1934 this ovary, together with the right Fallopian tube, was surgically excised. Postoperatively the surgical procedure was complicated by a thrombophlebitis of the right leg. Recurrent urinary symptoms developed at this time and continued until 1937 when she had a left nephrectomy. In 1940 she had a hemorrhoidectomy. In 1953 she was in an automobile accident and had a skull fracture. She was then well until June of 1963 when she became ill with chills and fever and was admitted to the hospital with fever and right sided flank and suprapubic pain of four days duration.

Physical examination revealed tenderness in the right flank and right lower quadrant. The urine had a specific gravity of 1.010, pH 6, one plus proteinuria and 15 to 25 white blood cells per high powered field. The hemoglobin was 14.5 grams percent, hematocrit 43 percent, white blood count 19,400 cells per cubic millimeter. The differential count showed 77% segmented neutrophils, 15% nonsegmented neutrophils, 8% lymphocytes. A blood Kahn was negative. The blood urea nitrogen was 112.5 mg.%; fasting blood sugar 110 mg.%; serum creatinine 3.47 mg.%. Cultures of the urine revealed E. coli. Retrograde pyelography showed a rounded renal

* Eaton Laboratories.

shadow with marked deformity of the calyceal systems. The pelvis was of normal caliber and there was no evidence of obstruction.

Hospital course: Fever ranged from 98 to 103 degrees with chills. Initially she was treated with 2.0 grams Chloramphenicol daily in divided doses. On July 13 this was discontinued and Nitrofurantoin 400 mg. daily in divided doses was begun. This was continued until August 21, 40 days, 16 grams. Chills ceased but fever rose to 100.6 or 100.8 each afternoon. The blood urea nitrogen fell to 75 mg.% by July 24. She was discharged on July 25. Ten days later on August 5 she noticed numbness of her legs and hands. By August 12 she had burning and pain in all four extremities and trouble walking. She was readmitted to the hospital on August 21 with these symptoms. Nitrofurantoin was discontinued. On examination she had generalized weakness in her arms and legs; she was unable to stand; she had a bilateral foot and wrist drop; there were hyperaesthesias of all four extremities, most marked distally. Her temperature was 102 degrees; the urine showed a specific gravity of 1.010, pH 6, two plus proteinuria, negative test for reducing substances, 20 to 30 white blood cells and 10 to 20 red blood cells per high powered field. The blood urea nitrogen was 117 mg.%, blood creatinine 4.24 mg.%, hemoglobin 7.6 gm.%, hematocrit 25%. The white blood count was 27,000 cells per cubic millimeter; differential count 92% segmented neutrophils, 6% lymphocytes, 2% non-segmented neutrophils. A lumbar puncture was done which showed an opening pressure of 140 mm. of water; the spinal fluid was clear, the protein was 55.5 mg.% with 1 white blood cell per cubic millimeter on differential count. The spinal fluid serology and culture were negative and the gold curve was flat. Urine culture showed E. coli.

She was treated with intravenous fluids and whole blood. Temperature fell to normal but the blood urea nitrogen rose gradually to a peak of 247 mg.% on August 30. Urine output ranged from 1 to 2 liters daily. On August 28 she was nauseated and vomited small amounts. On that evening she had epigastric pain and the following day epigastric pain was severe. On August 30 the pain was still more prominent with local tenderness and some abdominal distension. Late in the day on August 30 the pulse rate rose, the blood pressure fell to unobtainable levels, the skin became cold, moist and she was unresponsive and died suddenly on the evening of August 30.

An autopsy was performed on August 31. The body was well developed. Positive findings were limited to the abdominal cavity and the nervous system. The abdominal cavity in the left upper quadrant showed evidence of hemorrhage into the soft tissues surrounding the pancreas. The entire pancreas showed focal areas of hemorrhage and slight necrosis. Surrounding the pancreas there were areas of fat necrosis. The right kidney weighed 200 grams, the capsule stripped without difficulty revealing a smooth, mottled, pinkish-gray surface. On cut section the cortex and medullary tissue showed mottling and discoloration. In one area there was an abscess measuring 8 mm. in diameter. The pelvis and ureter were normal. The left kidney was not present. Examination of the central nervous system grossly was not unusual. On microscopic examination there were marked changes in the entire spinal cord. These were most remarkable in the anterior horn cells. These cells showed marked swelling. The nuclei were eccentrically placed and the cellular cytoplasm stained in a homogeneous fashion. There was marked evidence of chromatolysis. Sections of the peripheral nerves revealed slight degeneration of myelin.

Discussion

Neurologic abnormalities coincident with the use of Nitrofurantoin have been described since early usage of this chemical. These have been more prominent when the drug was used in the presence of chronic renal failure or used in high doses. Most of the reported cases have been patients with impaired renal function and the literature provided by the manufacturer stresses

this point. There has been some suggestion that coincident anemia may, in some unknown fashion, contribute. When recognized early and when renal function is adequate, withdrawal of the drug has resulted in remission of symptoms. In some occasions reinstitution of the drug has resulted in a return of the polyneuropathy. In the case at hand renal disease and finally the acute pancreatitis resulted in the death of the patient. In one case described in the literature the polyneuritis resulted in respiratory paralysis and directly contributed to the death of the patient[3]. Almost certainly, chronic or subacute renal insufficiency together with pancreatitis were the leading factors in our patient's demise. Had she survived, however, it is difficult to believe that her neurologic disorder would have remitted. Despite wide use of Nitrofurantoin in clinical practice, few complications of this nature have been reported. Mainfestations of toxicity in this case and in others have been pain and weakness with distal, sensory and motor changes involving all four extremities.

References

1. Rubenstein, Carl J.: Peripheral Polyneuropathy Caused by Nitrofurantoin, *JAMA* 187:647, 1964.
2. Martin, W. J., Corbin, K. B., and Utz, D. C.: Paresthesias during Treatment with Nitrofurantoin, *Proc. Staff Mayo Clinic* 37:288, 1962.
3. Hafstroem, T.: Prognosen vid Furadantin—polyneurit, *Opuscula Medica* 4:17, 1959.
4. Briand, P. and Tygstrup, I.: Polyneuritis after behandling med Nitrofurantoin, *Ugeskr. Laeg.* 121:664, 1959.
5. Lee, M. L. H.: Toxic Effects of Prolonged Treatment with Furaltadone, *Lancet* 2:374, 1960.
6. Hussain, K. K., and Koilpillai, H.: Toxic Effects of Furaltadone, *Lancet* 2:490, 1960.

MOVING SOON?

Let Your IMJ Move With You!

The Post Office will not forward the Illinois Medical Journal from your old address. Make certain you keep getting your Journal by filling in and mailing the form below to: The Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601. Do it now!

Name.....

Old Address.....
(number) (street)

.....
(city) (state)

New Address
(send IMJ here).....
(number) (street)

.....
(city) (state)

THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

This 47-year-old, white male entered the hospital with a one-week history of cough, high fever, chills and hemoptysis.

Physical examination revealed an increase in dullness over the right upper lobe with occasional moist rales. The remainder of the physical examination was essentially normal.

The WBC's were 21,000, with 80% polymorphonuclear cells.

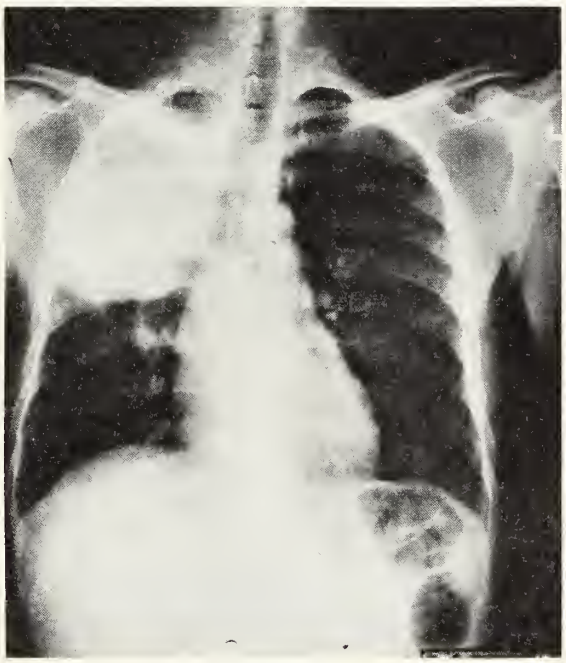


Figure 1

What is your diagnosis?

1) Fungus ball R.U.L.
2) Carcinoma of the R.U.L.
3) Loculated pleural effusion
4) Friedlander's pneumonia R.U.L.

(answer on next page)

THE VIEW BOX

DIAGNOSIS AND DISCUSSION

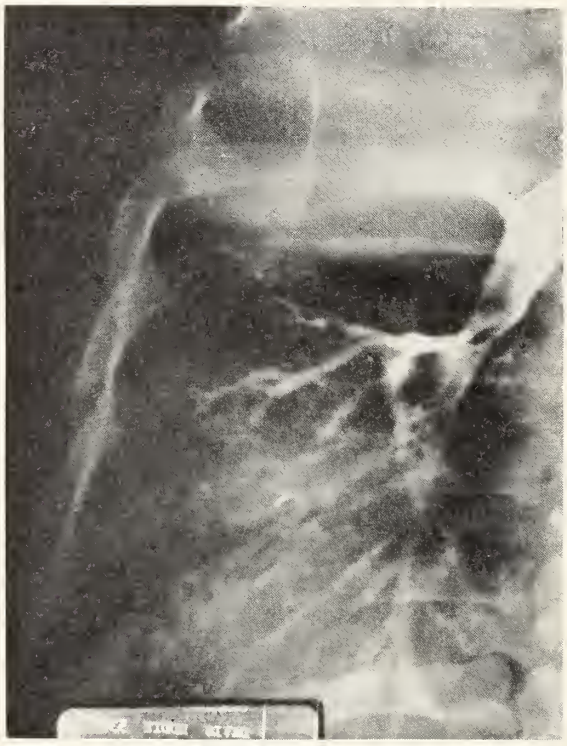


Figure 2

Diagnosis: Carcinoma right upper lobe.

It is not infrequent that a carcinoma of the lung will present clinically as a pneumonitis as this case does. Inspection of the PA chest film reveals some interesting findings, which lead to a radiographic diagnosis of carcinoma.

There is a massive right upper lobe consolidation with sagging of the horizontal fissure downward. This finding by itself is frequently found in Friedlander's pneumonia, particularly if there is cavitation. The slight shift of the trachea to the right and the gradual narrowing with amputation of the right upper lobe bronchus on the PA chest film is highly suggestive of a tumor which has invaded the bronchus just distal to its origin. This is easily confirmed by bronchography (Figure 2). In infection we usually see bronchial dilatation rather than bronchial occlusion, but occlusion can occur in infection by blocking with mucous plugs. The sagging of the fissure is undoubtedly due to "drowned lung" distal to the right upper lobe obstruction.

Bronchoscopy confirmed the diagnosis of squamous cell carcinoma right upper lobe.

Reference

Molnar, W. and Riebel, F. A.: Bronchography: An Aid in the Diagnosis of Peripheral Pulmonary Carcinoma. *Rad. Clinics of North America.* 202:303-314, August 1963.

An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus... Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

TAO®
[triacetyloleandomycin]

ROERIG Rx

J. B. Roerig and Company, New York, New York 10017
Division, Chas. Pfizer & Co., Inc., Science for the World's Well-Being®

TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylocci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References:** 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science **1**:185-256 (July-Aug.) 1964.

EDITORIALS

MILK AND THE SPASTIC BOWEL

Some patients with the irritable bowel syndrome have lactose deficiency and the abdominal cramps, gas and diarrhea disappear when milk products are withheld from the diet. Weser, et al.[1] made the observation on 27 persons suffering from these symptoms for a period of two to 30 years. No single food substances caused flatulence and cramping but 10 patients thought that milk was one of several noxious foods. Not more than one or two glasses of milk was consumed daily by any of the patients.

Following the ingestion of a test dose of lactose, 14 of the 27 patients showed a flat lactose tolerance curve. In addition, these individuals experienced abdominal cramps and diarrhea within one to six hours after lactose ingestion. Only one of those with normal lactose tolerance suffered these symptoms. Biopsies of the jejunal mucosa were obtained for lactose activity and the concentration was significantly lower in 13 of those with a flat lactose tolerance curve as compared with normal individuals and those with normal lactose tolerance curves. Milk was restricted from the 13 persons with definite lactose deficiency and eight noted striking symptomatic improvement.

Milk intolerance has been a common finding in many gastrointestinal disorders. There is a possibility that milk allergy exists when there is no evidence of lactose deficiency. On the other hand many of these persons have laboratory incidence of lactose deficiency but do not respond to withdrawal of milk products. In these instances the symptoms are unrelated to lactose deficiency.

Weser, et al. concluded that a significant number of patients with the diagnosis of "irritable colon syndrome" have a lactose deficiency and that symptoms may improve on a lactose-free diet.

T. R. Van Dellen, M.D.

Reference

1. Weser, Elliot, et al. Lactose Deficiency in Patients with the "Irritable Colon Syndrome." *The New England Medical Journal*, 273:1070 (November 11) 1965.

CARDIAC ARRHYTHMIAS IN PREMATURE INFANTS

Electrocardiograms performed in premature infants during the neonatal period indicate that cardiac arrhythmias are rare. The electrocardiograms were previously done with routine standard tracings. Dr. Beverly C. Morgan and her group have reported on the results of electrocardiograms taken on premature infants using a special transistorized electrocardiographic tape recorder which allows a continuous monitoring of the infants, electrocardiogram.* They recorded EKGs for as long as five hours on infants during feeding, defecation, sleeping and waking.

These investigators found a high incidence of marked sinus arrhythmia, sinus bradycardia and nodal rhythm. The episodes of sinus bradycardia were noted primarily during sleep. Heart rates below 50 per minute were recorded. Similar findings have

* Avionics Research Products Corporation, 6901 West Imperial Highway, Los Angeles 45, California.

to help relieve pain in common anorectal disorders

"non-caine" Diothane®

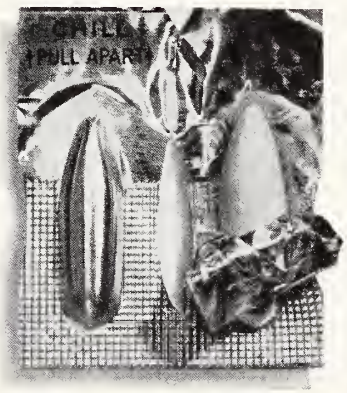
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

THANE OINTMENT

MPOSITION:
rodon 1.0%; oxyquinoline oate 0.1% in a special ointbase.

ICATIONS:
ides temporary palliation of that may result from hemorlectomy and from common ctal disorders such as hemorls, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215/Weston, Ontario

been recorded using somewhat prolonged electrocardiographic tracings by Raiha in 1935, who noted transient arrhythmia in 17 of 95 premature infants.

Richmond and his group have noted marked bradycardia in small prematures associated with esophageal intubation, hiccoughs, yawning and defecation.[2] Unfortunately no ECG tracings were done. We have noted two cases of sudden bradycardia in two full term new born infants with a fall in the cardiac rate to 80 per minute associated with cyanosis. In both instances the infants were stimulated cutaneously followed by aspirations of the naso-pharynx. The infants began to cry and the cyanosis disappeared. An immediate routine ECG using the short rapid standard technique failed to show the bradycardia which was previously noted by the nurse while charting the vital signs. These occurrences are not uncommon to newborn nurseries. It is probably that cases of this type could be uncovered and documented more frequently by using the long tracing technique for performing ECGs as advocated by Morgan's group, especially if the EKGs are taken during sleep.

The relationship between the arrhythmias as in the premature infants and the sudden death syndrome in infants 2 to 5 months was mentioned by the authors. More data on long term tracing ECGs in this age group as well as the neonatal period must be obtained before relationship can be established. The technique of obtaining long ECG tracings described by Dr. Morgan deserves widespread use both in the newborn period and throughout infancy and childhood.

Harvey Kravitz, M.D.

References

1. Morgan, B. C., Bloom, R. S. and Guntheroth, W. G.: Cardiac Arrhythmias in Premature Infants, *Pediatrics* 35: 658, 1965.
2. Raiha, C. E.: Das electrokardiogram des Fruhgeborenen, *Acta Paediat.* 18:440, 1936.
3. Lipton, E. L., Steinschneider, A. and Richmond, J. B.: Autonomic function in the Neonate VIII: Cardio-pulmonary observations. *Pediatrics* 33:212, 1964.

A PLEA FOR COOPERATION

Obedience to the Illinois Narcotic Drug Laws requires doctor and pharmacist to work together; it cannot be accomplished if one or the other neglects his part.

For the physician the law reads: "All prescription for narcotic drugs, except oral prescription narcotic drugs and exempt preparations . . . shall be written on the official prescription blanks . . . The practitioner shall give the original and one copy to the patient to be filled by the pharmacist."; and for the druggist, the law is: "A pharmacist shall only fill written narcotic drug prescriptions . . . which are issued by a practitioner in this State, on the official prescription blanks."

Certainly, it is easier and saves the busy, harried physician time and trouble to pick up the phone and tell the local druggist to give so many tablets of Demerol to Mrs. X when she stops by. Easier—and illegal.

Consider the druggist's dilemma: if he refuses your request he may be insulting an "old friend" and colleague by his lack of trust in you (perhaps "old friend" threatens to take his business elsewhere); if he honors your telephone prescription he is breaking the law of the land and you are aiding and abetting him to do so. He does not want to be caught without the prescription.

Write your narcotic prescription on the official prescription blanks and use your narcotic registration number. In this way, both you and the pharmacist—and ultimately the patient—are protected.

T. R. Van Dellen, M.D.



1. YOUR SUPERVISION



2. "TRICKLE RELEASE" OBEDRIN-LA



3. OBEDRIN MENU PLAN

A WEIGHT CONTROL PROGRAM YOUR PATIENTS WILL STAY WITH . . . AND FEEL BETTER

1. YOUR SUPERVISION orients the patient to the need, goals and course of weight reduction . . . regular checkups confirm progress and support patient's morale.

2. OBEDRIN-LA: 1 tablet daily "trickle releases" medication for all-day appetite suppression.

3. OBEDRIN MENU PLAN: . . . aids weight reduction . . . provides a plan for necessary nutritional support and helps patients establish better eating habits.

Write today for free starter doses and Menu Plans, or contact your Massengill Representative.

DOSAGE is 1 tablet daily, usually at 10 a.m.

SUPPLIED in bottles of 50 and 250 tablets, on prescription only.

CAUTION: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage. Use with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution during pregnancy, especially in the first trimester.

LONG ACTING

Obedrin®-LA*

"TRICKLE RELEASE" TABLETS

Each tablet contains Methamphetamine HCl*, 12.5 mg.; Pentobarbital*, 50 mg. (Barbituric Acid derivative; Warning: May be habit forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Niacin, 10 mg. *U. S. Pat. Nos. 2,736,682; 2,809,916; 2,809,917; 2,809,918 and pat. pending.

MASSENGILL The S. E. Massengill Company, Bristol, Tennessee
New York • Chicago • Dallas • Kansas City • San Francisco

ILLINOIS STATE MEDICAL SOCIETY
CONFERENCE ON NARCOTIC ADDITION

MARCH 24-25, 1966 SHERMAN HOUSE CHICAGO, ILLINOIS

PROGRAM

March 24

1:30-2:00 p.m. Opening
Joseph H. Skom, M.D., Chairman, ISMS Committee on Narcotics
Orientation
Burtis E. Montgomery, M.D., President, Illinois State Medical Society
Remarks
Hugh H. Hussey, Director of Scientific Activities, American Medical Association

2:00-5:00 p.m. Session One: "The Addict and the Drug"
James Eckenhoff, M.D., Moderator
Panel A
"Pathology of Addiction"
James Eckenhoff, M.D., University of Pennsylvania Medical School; Pennsylvania Task Force on Addiction
"Pharmacology of Addiction"
Theodore R. Sherrod, M.D., Ph.D., Professor of Pharmacology, University of Illinois Medical School
"Addictive Drugs"
Leo Abood, Ph.D., Professor, Center for Brain Research, University of Rochester Medical School
Panel B
"Definition and Description of Addiction"
Vincent Dole, M.D., Rockefeller University, New York
"Description and Therapy of Withdrawal"
Marie Nyswander, M.D., Rockefeller Foundation, New York
"Relapse and Narcotic Antagonists"
William Martin, M.D., Director, Addiction Research, U. S. Public Health Hospital, Lexington, Kentucky

6:30 p.m. Conference Dinner
Speaker To Be Announced

March 25

9:30 a.m.-12 noon Session Two: "The Addict and the Community"
Alfred R. Lindesmith, Ph.D., Moderator
Panel A
"Sociology of Addiction"
Alfred R. Lindesmith, Ph.D., Professor of Sociology, Indiana University
"Epidemiology of Addiction"
Hans Mattick, Associate Director, Center for Studies of Criminal Justice, Law School, University of Chicago
"Programs for Addiction"
James H. Fox, M.D., National Institute of Mental Health
"Community Approaches to Addiction"
Rev. R. Bruce Wheeler, Chaplain, House of Correction; Chairman, Council for the Understanding and Rehabilitation of Addicts
"Enforcement of Narcotic Laws"
George Gaffney, Deputy Commissioner, U. S. Bureau of Narcotics
"The Legislator Looks at Addiction"
The Honorable James Moran, Member, Illinois General Assembly
"The Legislator Looks at Addiction"
The Honorable Nicholas Zagone, Member, Illinois General Assembly
"Economic Impact of Addiction"
O. W. Wilson, Superintendent, Chicago Police Department

1:30 p.m. Session Three: "The Addict and Treatment"
Harold Visotsky, M.D., Moderator
Panel A
"Mental Health Logistics"
Harold Visotsky, M.D., Director, Illinois Department of Mental Health
"Psychiatry and Behavior in Addiction"
Thaddeus Kostrubala, M.D., Director, Chicago Department of Mental Health
"Profiles of Addiction"
Jordan Scher, M.D., Consulting Psychiatrist, Chicago Board of Health
Panel B
"Treatment of Addiction"
Herbert Raskin, M.D., Former Director, Narcotic Clinic, Detroit, Michigan
"Rehabilitation of Addicts"
Roland Wood, Superintendent, California Rehabilitation Center
"Aftercare for Addicts"
Rev. Daniel Egan, Author, "The Junky Priest"
"Management of Addiction"
David Ausubel, M.D., Ph.D., Director, Bureau of Educational Research, University of Illinois
Concluding Remarks
Karl Menninger, M.D., Menninger Psychiatric Clinic, Topeka, Kansas

(Registration by reservation only. Fee $20.00. Write Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Illinois 60601 for reservation form.)



Taking an ECG?

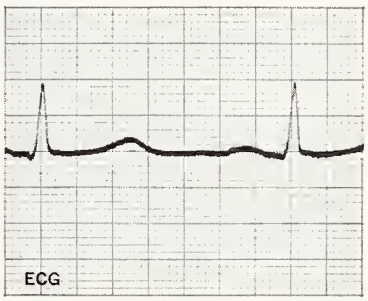
Complete** the clinical picture with **a heart sound recording

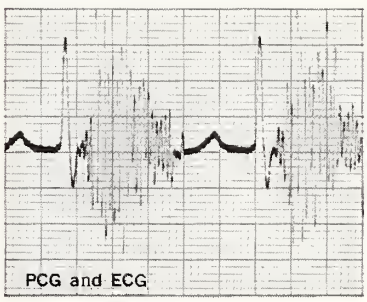
...made on your 500 VISO when you take the ECG

Increase your knowledge of cardiac condition with the valuable *additional* information provided by heart *sound* recordings. With this new Sanborn Heart Sound Amplifier clipped to the front of your 500 VISO* you can immediately obtain clear, sharply defined, graphic records — which identify the *location, intensity* and *duration* of the sounds and murmurs within the cardiac cycle. Even in the presence of complex arrythmias, marked tachycardias and other conditions which may complicate or prevent accurate auscultation by stethoscope alone, a definitive record of diagnostic quality can be obtained with this new instrument. Frequency cutoffs of 50, 100, 250 and 500 cps can be switch-selected to separate murmurs which might otherwise be masked by other heart sounds. As an electronic stethoscope, all sounds from 50 to 2000 cps can be heard at normal or amplified levels.

This precise Sanborn amplifier has convenient controls for recording the ECG, PCG, or ECG superimposed on the PCG . . . Cutoff Frequency . . . Audiophone Volume . . . and Sensitivity. Complete with contact microphone, cable and Audiophone (for use as an electronic stethoscope), Model 1506A is $450 f.o.b. Waltham, Mass. (continental U.S.). For more information, use the convenient coupon below. Sanborn Division, Hewlett-Packard Company, Waltham, Mass. 02154. In Europe, Hewlett-Packard S.A., 54 Route des Acacias, Geneva.

**or almost any other ECG with a 50 mm/sec. chart speed.*





☐ Send detailed specifications on Sanborn 1506A Heart Sound Amplifier.
☐ Have HP/Sanborn Field Office call me for an appointment.

(address) (phone)

(city) (state) (zip code)

2R1

HEWLETT PACKARD hp SANBORN DIVISION

YOUR STAKE IN MANPOWER

In recent months, the need for immediate planning for health manpower needs and expanding recruitment efforts has become evident. Illinois was one of the first of the 22 states that now have a cooperative agency for this purpose. The Health Careers Council of Illinois serves the health professions, employers of health personnel, the field of education, and young people by developing and stimulating effective health careers guidance activities and information.

The Council seeks the causes and solutions to health manpower shortages. Our philosophy is to provide leadership and initial program activities that motivate and guide development of health careers guidance activities. The Illinois State Medical Society is a member, and many of the Council's activities are conducted in the local communities by medical society auxiliaries.

You are aware of how rapidly the demand for allied medical arts personnel has grown. For every 100 physicians in 1900 there were 60 health personnel. There are now over 375 for every 100 physicians. From 1950 to 1960 there was a 42% increase in health personnel, and still the demands for more personnel continue to grow.

In Illinois during the past two years budgeted hospital vacancies for general duty nurses have risen 65%. There has been an 89% increase in the vacancies for dietitians and a 35% increase in the vacancies for physical and occupational therapists. Total budgeted vacancies in our hospitals are up 78% from just two years ago.

The Council is mobilizing to meet the problem of these shortages. During the last year alone it provided for workshops attended by more than 1,500 volunteer workers in health careers recruitment. Health careers conferences and lectures reached 15,000 young people and parents. The Council's exhibits and media-disseminated information reached over 2½ million Illinois citizens. But if our program is to become truly effective and meet the competition from other industries, we must have larger financial participation from those most truly concerned. We hope that you—the leader of the health team—will affiliate yourself with this program through your financial contribution.

Your contribution, which is fully tax deductible, can be made by completing the coupon below. In doing this, you will assist the Council in:

1. The study of health manpower shortages in Illinois and their causes.
2. The development and expansion of health careers education programs.
3. The development and expansion of health careers recruitment activities.

Help us make possible the *voluntary* solution of our health manpower shortages.

Maynard I. Shapiro, M.D.
Chairman, ISMS Advisory Committee
to the Health Careers Council of Illinois

Health Careers Council of Illinois
400 North Michigan Avenue
Chicago, Illinois 60611

Please enroll me as an associate member in the Council. To assist the Council in our fight against health manpower shortages I have enclosed my check for $_____.

_____, M.D.

(Address)

Special cough formula for children

Pediacof®

Each teaspoon (5 ml.) contains codeine phosphate 5 mg., Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg., chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



relieves cough
nasal drip
congestion
running nose
sneezing

eases expectoration

bright red, pleasant-tasting, raspberry-flavored syrup

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, ¼ teaspoon; from 1 to 3 years, ½ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

Winthrop Laboratories
New York, N.Y.

Winthrop



Anatomy and Surgical Technique of Groin Dissection. Spratt, John S., Shieber, William, and Dillard, Burl M. The C. V. Mosby Company. St. Louis, 1965.

There are few institutions that have had the extensive experience with groin dissection which the Ellis Fischel State Cancer Hospital has so nicely recorded. This publication presents its experience over a period of 25 years with various cancers that metastasize to the groin. The study is divided into three parts: Anatomy of the Ilioinguinal Region, Surgical Technique of Groin Dissection and Indications for Groin Dissections.

The anatomy of the ilioinguinal region is presented in a well edited, direct, lucid manner. Emphasis is placed on the position and relationship of the lymph nodes and their interconnecting channels. These are well illustrated with diagrams and lymphangiograms. This chapter provides a sound anatomical background for the clinical aspects of groin dissection in the subsequent section.

The authors explain, from their choice of incision to the route of access to the deep iliac lymph nodes, why they prefer a particular technique. The many details that help minimize the morbidity of this procedure are properly emphasized.

The indications for groin dissection chapter permits the reader to review the experience of the Ellis Fischel Hospital with diverse cancers that metastasize to the groin. This data is then tested statistically to determine the efficacy of groin dissection. Controversial questions that can not be answered by such an approach are discussed with candor and obvious extensive knowledge as to the currently known interplay between host and invading cancer.

This book can be enjoyed by all physicians and is strongly recommended for those working in this field.

Paul H. O'Brien, M.D.

Foundations of Anesthesiology. Albert Faulconer, Jr. and Thomas E. Keys. 2 Volumes, 1337 pages, illustrated. Springfield, Ill. Charles C Thomas, Publisher, 1965.

The authors have set out ". . . to assemble from the vast and disordered archives of the past a few pertinent highlights . . . which will comprise an 'Autobiography of Anesthesiology.'" They have succeeded well in their task. One hundred and fifty-one articles, from that of Peter of Anghiera on curare in 1516 to Linus Pauling's *A Molecular Theory of General Anesthesia*, published in 1961, are included in these two volumes. Short biographies of the authors precede each article. The first section concerns respiratory physiology and is followed by five sections on the agents and techniques for anesthesia. The final two sections deal with determination of depth of anesthesia and theories of narcosis. Many of the papers make fascinating reading with their descriptions of experiments carried out centuries ago; for instance, Sir Christopher Wren's experiment in which he narcotized a dog with intravenously administered opium in 1665 or Claude Bernard's experiments on the curarization of animals. History humbles one; as the reader progresses through the centuries he notes how much of "modern" medical practice and how many discoveries of "modern" science actually antedate his grandfather.

One curious feature is the repetition of biographies of authors each time one of their works appears. Ralph Waters' biography appears four times and Claude Bernard's, three. We would have preferred to have seen this space devoted to a paper or two on fluorinated anesthetic agents which are conspicuous for their omission.

These volumes are excellent for reference, containing as they do much that often is not readily

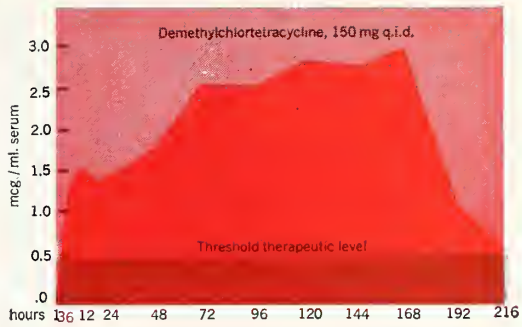
(continued on page 186)



greater potency

lower mg intake per day

600 mg versus 1,000 mg



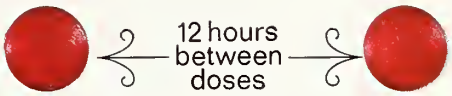
higher activity

higher activity levels with less peak-and-valley fluctuation

(Adapted from Sweeney, W. M.; Dornbush, A. C. and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.)



1-2 days' "extra" activity



one 300 mg Tablet mid-morning

one 300 mg Tablet mid-evening

It's made for b.i.d.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE

Effective in a wide range of everyday infections — respiratory, urinary tract and others — in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Side effects typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

Capsules, 150 mg and 75 mg of demethylchlortetracycline HCl.

Tablets, film coated, 300 mg and 150 mg of demethylchlortetracycline HCl.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6795-2991

Lederle

(Book Reviews continued from page 182)

accessible. They are recommended for the libraries of anesthetists, pharmacologists and medical institutions. It is unfortunate that young physicians and students who might benefit the most from these books will be deterred from their purchase by the price.

Harry W. Linde, Ph.D
James E. Eckenhoff, M.D.

BIOPHYSICAL MECHANISMS IN VASCULAR HOMEOSTASIS AND INTRAVASCULAR THROMBOSIS. Edited by Philip N. Sawyer. Appleton-Century-Crofts, New York, 1965. 379 pages, $8.95.

Some believe there should be no mourning over the passing of the classical textbook from the medical scene. The old tomes as put together largely by one man like Osler or Homans were perhaps too voluminous, cumbersome, prejudicial, rambling. But they had continuity and style. It is certain that small corners of medical knowledge are now so complex that an individual can only be fractionally authoritative although wholly informed. Nevertheless, one can only be appalled by the advent of the instant textbook which this volume typifies. This new breed is the product of a short meeting of experts who present *avant garde* information concerning personal research in the relatively disconnected niches within a larger framework of medical activity. Inevitably, such books contain a quantity of information, enormous amounts of data and fascinating new ideas. But the discontinuity is disappointing, the shiny insights are unseasoned by time, conclusions given are unsupported by the data and the data are unconfirmed by other investigators. In such a collection, the thread of continuity is given only by the obvious pressure of time as evidenced by the chairman's remarks and a tawdry substitute for style and grace is provided by discussants' remarks occasionally punctuated by (laughter).

But such a book has merit, too. It may serve, as this one does, to emphasize a new, important area of knowledge. In this instance surface chemistry, physiochemistry, interfacial phenomena and electrokinetic activity are related to blood clotting. Thus physical, chemical and biochemical phenomena are brought into a relationship which was formerly appreciated by only a few researchers most of whom find representation in the table of contents.

One can judge this volume best by noting the titles of its four sections. These are: Fundamental Electrokinetic Phenomena; Bioelectric Phenomena, Surface Effects, Blood Clotting and Thrombosis; Rheology of Blood Flow and Relation of Basic Electrochemical Phenomena to the Vascular Tree; and Electrochemistry, Surface Physics and Insight into Construction of a Suitable Vascular Interface. These are appropriately encased in a splendid example of printing art.

John J. Bergan, M.D.

DEPROL®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-6408

When insomnia is a problem in the



complex

TRY DEPROL®–

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

A LOGICAL FIRST CHOICE

usually restores
normal sleep quickly
by helping
to lift depression…
calm associated anxiety,
tension, and rumination

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-6408



Dr. SIMS in ACTION

ADMINISTRATIVE AND COMMITTEE ACTIVITIES OF THE ILLINOIS STATE MEDICAL SOCIETY

February, 1966

Finance Committee Reviews 1966 Budget

Meeting December 18-19, the Finance Committee of the Illinois State Medical Society considered the budget for 1966. Present were Dr. Carl E. Clark, chairman, and Drs. Jacob E. Reisch, Ralph N. Redmond and Philip Thomsen. Also present for periods of time during the discussion of the budget were Drs. W. I. Taylor, Maurice M. Hoeltgen and William Adams.

Before getting to the budget, which was the main order of business, several items were brought forward for discussion.

The dues statement for 1966 was reviewed and the direct billing procedure, which had been accepted by 51 county medical societies, was accepted.

Correspondence from the actuarial consultant regarding the special retirement plan was considered. It was agreed that since the funding of this plan had previously been approved by the Board of Trustees, and because the actuarial figures did not exceed the original estimate, the Executive Administrator could now proceed to implement the establishment of a special fund.

It was reported that several hundred members had not paid supplemental dues for 1965. In the preparation of the 1966 statement the $25 will be shown as an arrears and the 1966 dues will not be acceptable unless the 1965 dues are paid in full.

The committee reviewed and accepted the October 31, 1965 financial report of the General Fund, the Benevolence Fund and the Educational and Scientific Foundation.

The committee met with a number of committee chairmen and interviewed staff directors, the business manager and the Executive Administrator on the proposed budget distributed to the Finance Committee with appropriate notations. Every item within the budget was reviewed and the committee made a preliminary determination of the amount of money to be assigned to each committee and activity of the society.

Further consideration of the budget and additional discussions enabled the Finance Committee to resolve the General Fund Budget, including $19,900 to be assigned to contingency reserves. The details of this budget were presented to the Board of Trustees at its meeting on January 15, 1966.

The recommendation of the delegation to the AMA regarding attendance at the Saturday evening meetings of the Board of Trustees, and Sunday morning breakfast meetings of the delegation on weekends of the Board meetings was given favorable consideration and an approved allocation is included in the proposed 1966 budget.

ISMS Committee Structure Outlined By Committee on Committees

The following recommendations on the structure and composition of committees of the Illinois State Medical Society were among those made to the Board of Trustees by the Committee on Committees, meeting October 23:

Membership on Committees should be composed of physicians definitely interested in the subject and willing to serve and each physician should be limited to membership

(continued on page 190)

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

SCHOLARSHIP LOAN PROGRAM

FOR MEDICAL ASSISTANTS

Another milestone of progress was passed at the 1965 Convention of the American Association of Medical Assistants when the first five Maxine Williams Scholarship awards, of $300 each, were announced. This scholarship loan program was established in 1959 by Miss Maxine Williams, AAMA's first president, and is a fund entirely supported by contributions from members and other interested groups.

To qualify for such a loan, an applicant must be a high school graduate; of good character as attested to by a letter from her school principal or counsellor and one from her minister, attorney, physician, etc.; and indicate an interest in becoming a certified medical assistant. After selecting her course and school (from those approved by the local medical assistants chapter and its medical advisors), she must submit to the local chapter a copy of the application form sent to the school, the type of program available and a letter stating her reasons for wanting to become a medical assistant. She must also agree in advance that if she is awarded a scholarship, she will repay the loan when she becomes employed. This is a matter of honor and no note is signed.

The local medical assistants chapter then forwards this material along with a scholarship application to the Scholarship Committee. The awards are made to the local chapters whose proposed candidates and schools seem best to fulfill the hopes of the training program for medical assistants. Each chapter administers the loan and reports to the Scholarship Committee semi-annually.

Scholarships are available for qualified candidates. If you are interested or know someone who is interested, write to the following address for additional details: Mrs. Dene R. Murray, Executive Director, American Association of Medical Assistants, 501 North Dearborn Street, Chicago, Illinois 60610.

Anyone who would like to make a contribution to this fund may send donations to the same address. The Illinois Medical Assistants Association contributes to this program annually at the time of its convention, as do the county chapters.

It is not too early to make plans for your medical assistant to attend the 10th annual state convention of the Illinois Medical Assistants Association. It will be hosted by the McLean County chapter and held in Bloomington, April 22-24. More details will appear in future issues.

on one committee, although he may serve as "consultant" to others.

Chairmen should report attendance at meetings and make recommendations for the evaluation of future appointments. They should also submit a proposed program and budget and assure that both are understood by committee personnel.

The number of physicians appointed to committees from any one trustee district should be based upon the physician population of that district.

Committees should be informed that they may NOT MAKE POLICY, but may suggest such action to the Board for consideration until such time as the House of Delegates has an opportunity to act.

Non-members of ISMS may be appointed as consultants to important committees.

No member of the "official family"—officers, trustees, speaker and vice-speaker of the ISMS House and Delegates to the AMA House—shall have appointments on committees.

The Committee asked that its members be furnished with a record of attendance at committee meetings during the past year or 18 months and that the chairmen of the committees and the staff directors be asked to submit a general statement relative to the manner in which the committee has functioned and fulfilled its duties as outlined during the past year.

This material is to be checked over by the Committee so that a detailed report may be presented to the House of Delegates in May of 1966.

Public Affairs Committee Outlines Plans for 1966

The Public Affairs Committee, at its December 18 meeting, planned the following activities to more effectively motivate and inform ISMS members during this vital election year:

On Saturday, March 26, the committee will present an all-day "Public Affairs Workshop" at the Sherman House, Chicago. A top-level program is planned for this conference to present greater insight into the workings of politics. The entire ISMS membership is invited to attend at their own expense.

The committee has obtained Mr. Charles Shuman, president of the American Farm Bureau Federation, as the main speaker for the 1966 Public Affairs Annual Dinner, which will be held on Monday evening, May 17, in conjunction with the Annual Meeting. Mr. Shuman, who is from Sullivan, Illinois, is a nationally known spokesman for responsible government and was featured on the cover of "Time" magazine during 1965.

Home discussion sessions designed to generate interest in the mechanics of politics are under way in Cook County for physicians and wives. Hosts for future sessions are now being actively sought.

The committee will encourage county medical societies to conduct meetings at which all candidates for office (especially for state representative and, in some areas, state senator) can appear before members and their guests to explain their qualifications. These meetings would not be held for endorsement purposes, but rather to better acquaint our members with candidates and politics in general, and to gain the good will of the candidates themselves by providing a forum from which they can reach voters who might not normally attend a political meeting. Materials to guide county public affairs chairmen are being prepared.

ISMS Museum Is Chief Project of Archives Committee

The Archives Committee of the Illinois State Medical Society met December 10; in attendance were Dr. Emmet F. Pearson, Chairman, and Drs. Carl W. Hagler, Clifford E. Smith and Leo Zimmerman.

The chairman reviewed the activities of the State of Illinois concerning the creation of a Lincoln Shrine Museum in the old State Capitol Building in Springfield. Invitations to bid on the dismantling and restoration of the building will presently be extended. The architect plans to raze the building block

DR. SIMS IN ACTION . . . *continued*

by block, erect a reinforced shell and restore the previously numbered blocks to their original position, preserving the 1837 design of the old building. It is anticipated that the restoration work will be completed by 1968.

A recapitulation of the ISMS museum project was presented, with emphasis on the fact that approval had been given to create an exhibit with artifacts representative of the doctors and illnesses in the life of Lincoln and his family. The committee agreed that a central lifesize exhibit within the four pillars in the room would be the feature display. Artifacts and memorabilia contemporary with the exhibit would be displayed in the perimeter of the room. Further action to create and establish the display will be deferred until adequate financing is arranged and the committee reviewed possible sources of funds.

Four recommendations were made by the committee as follows:

1). an extension of the special dues allocation for members for 15 years to raise approximately $150,000; 2). the possibility of borrowing funds against this projected allocation; 3). newspaper medical writers be encouraged to publish articles on the museum project, emphasizing that funds for such a museum may be donated to the museum's custodian, the Abraham Lincoln Association; and 4). that selected doctors write as individuals to the Governor expressing interest in the ISMS museum project and request the Governor to waive the $85,000 prorated cost of reconstruction assigned as a condition of participation by Mr. Clyde Walton, state historian.

The committee unanimously supported a motion to inform the House of Delegates that the Archives Committee is willing to guide, supervise, arrange and establish the medical museum, but that matters of financing and implementing must be done by the Society and that the Finance Committee be assigned the responsibility of embarking on a program to raise the required money for participation in the Lincoln Shrine Museum.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

FEBRUARY 27, 28 - MARCH 1, 2, 1966

Palmer House, Chicago

THIS CONFERENCE WILL BE OF INTEREST TO ALL PHYSICIANS. It will be presented in a manner designed to interest the generalist and specialist alike. *The program is presented by types of disease entities, not sectionalized by medical specialties.* All physicians, regardless of their field of interest, will find this program to be informative and useful.

For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 So. Michigan Ave.
Chicago, Illinois 60604

ISMS 126th ANNUAL CONVENTION

May 15-18

Sherman House, Chicago

Speakers Announced for Two Outstanding Events . . .

PUBLIC AFFAIRS DINNER

MONDAY, MAY 16

6:00 P.M.



Charles B. Shuman
President
American Farm Bureau Federation

CAMP MEMORIAL LECTURE

"THE DEVELOPMENT OF WEAPONS"

WEDNESDAY, MAY 18

2:00 P.M.



William M. Mebane, Ph.D.
Secretary
Thiokol Chemical Corp.

THE NORTH SHORE HOSPITAL

takes pleasure in announcing

A STRUCTURED PROGRAM
for
ADOLESCENT PSYCHIATRIC PATIENTS

Facilities for Continuing Education ◈ Individual and Group Psychotherapy
Complete Adjunctive Therapies

◈

Supervised by Staff Psychiatric Team
or
Directed as prescribed by referring physician

225 Sheridan Road Winnetka, Illinois

HI 6-0211

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO OFFICE: Tom J. Hoehn and E. M. Breier, Representatives
55 East Washington Street, Room 1334, Chicago 60602 Telephone: 312-782-0990
MOUNT PROSPECT OFFICE: Theodore J. Pondok, Representative
709 Hockberry Lane (P. O. Box 105) Mount Prospect 60056 Telephone: 312-259-2774
ST. CHARLES OFFICE: Joseph C. Kunches, Representative
1220 Wing Avenue, St. Charles 60174 Telephone: 312-584-0920
SPRINGFIELD OFFICE: William J. Nattermann, Representative
1124 South Fifth Street, Springfield 62703 Telephone: 217-544-225



Rx Reviews

and New Products

Pfizer Offers New Film on Erythroblastosis

A 16-mm. color film on the causes, detection and treatment of erythroblastosis—a disease in the newborn resulting from the incompatibility of blood between mother and child—has been prepared by Pfizer Diagnostics, department of Chas. Pfizer & Co., Inc., and is now available for showing to hospitals and blood banks throughout the country upon request.

The 36-minute sound film provides a thorough and professional coverage of *erythroblastosis fetalis* and should be highly informative for both experienced and student medical technologists. It shows an actual exchange blood transfusion and the complications that occur if erythroblastosis is not detected in time and properly treated.

The film also explains the importance of routinely screening all prenatals, regardless of the Rh blood factor, for irregular antibodies capable of causing erythroblastosis.

Although irregular antibodies are comparatively rare, they can be very dangerous. In the case of pregnancy, for example, these irregular antibodies may enter the fetal blood circulation from the mother's circulatory system and destroy red cells in the blood of the unborn infant. Whether the irregular antibodies result from incompatible Rh factors, or have the specificity to other blood group systems, their presence in the infant's blood creates the danger of erythroblastosis. The disease may occur as often as once in every 100 births.

Requests to view the film should be referred to local Pfizer Diagnostics salesmen or by writing to Pfizer Medical Film Library, 267 W. 25th Street, New York, N. Y. 10001.



"Cardio Clamp" Records Tracings

Continental Hospital Industries, Inc. has announced its new "Cardio Clamp," said to be an easy method of recording accurate electrocardiograph tracings by means of clamps that may be attached to arms and legs in seconds. The product consists of durable plastic clamps with silver electrodes which may be easily rinsed off and is packaged four to a set, ready for use.

For further information, write to the company at 18624 Detroit Avenue, Cleveland, Ohio.

Robins Combines Thiazide Diuretic and Reserpine

Exna®-R, combining a thiazide diuretic and reserpine in a single tablet for more effective management of hypertension, has been introduced by A. H. Robins.

Each white, scored tablet contains 50 mg. of Exna (benthiazide) and 0.125 mg. of reserpine and is packaged in bottles of 100 and 500.

Thiazide diuretics and the Rauwolfia alkaloids (reserpine) are recognized agents

for the management of hypertension. The simultaneous administration of a thiazide diuretic and a Rauwolfia derivative is said to produce an effect which exceeds that obtained with either agent alone.

Exna-R is indicated as exclusive or adjunct therapy in mild to moderate hypertension and as an adjunctive therapy in more severe hypertension. In the latter, initial control may be attempted with this drug before resorting to ganglionic blocking or sympatholytic drugs.

Exna-R is contraindicated in patients with hypersensitivity to sulfonamide derivatives or Rauwolfia alkaloids; severe mental depression; or anuria. Progressive renal and progressive hepatic disease constitute relative contraindications to the use of this drug. It should not be given concurrently with electroshock therapy. More detailed information concerning the use and administration of Exna-R is contained in the package insert.

Armour Offers New Synthetic Thyroid

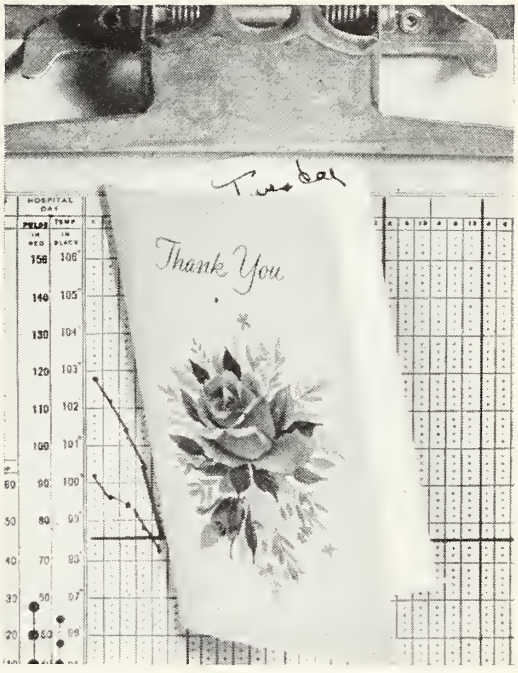
A potent synthetic thyroid hormone available in six different potencies is being introduced by Armour Pharmaceutical Company.

Named "Letter," the product is an improved sodium levothyroxine preparation.

Standard tests show Letter disintegrates within 16 seconds and over 98% is in solution within five hours. Rapid solubility is significant because authorities believe thyroxine absorption takes place in the upper intestine.

Letter is indicated in cretinism, myxedema, simple nontoxic goiter and in hypothyroidism, including that in children, in pregnancy and in the elderly. Contraindications are thyrotoxicosis, acute myocardial infarction, impaired adrenal cortical function and hyperadrenalism.

The six different potencies of the drug are available in bottles of 100 and each potency is in a different color: 0.025 mg. are violet; 0.04 mg. orange; 0.1 mg. pink; 0.2 mg. green; 0.3 mg. yellow; and 0.5 mg. white.



DID YOU EVER GET A "THANK YOU" NOTE FROM A SPECIAL-DIET PATIENT?

It can happen. Get hold of our free booklet and see the remarkable things that can be done with a diet that is built on Cream of RICE.

It's called "How To Make A Special Diet Taste Extra Special!" You'll find delicious recipes for bland, wheat-free, milk-free, egg-free and low-salt diets.

A recent research study compared the breakdown of Cream of RICE with oat, wheat, corn and barley cereals and concluded that Cream of RICE was easiest to digest.

Cream of RICE is fortified with Vitamin B_1, Riboflavin, Niacin and Iron. And it's low in residue and fat. The patient gets dietary protection, flavor satisfaction and good nutrition. And you may actually get a "Thank you."



ADVERTISED IN Reader's Digest

15½ million families (26 million worldwide) buy each issue.

CREAM OF RICE, Box IL 26, West Chester, Pa. 19380

Please send_____(state number desired) free copies of "How To Make A Special Diet Taste Extra Special!" to

Name_____

Address_____

City_____

State_____ Zip Code_____

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
Starting Dates — 1966

SPECIALTY REVIEW COURSE IN OB-GYN, Two Weeks, March 21
SPECIALTY REVIEW COURSE IN SURGERY, Part II, March 7
SPECIALTY REVIEW COURSE IN ORTHOPEDICS, April 18
SPECIALTY REVIEW COURSE IN PEDIATRICS, April 18
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
ESSENTIALS OF PLASTIC SURGERY, One Week, March 28
GENERAL SURGERY, One Week, March 21
GALLBLADDER SURGERY, Three Days, March 7
SURGERY OF HERNIA, Three Days, March 10
FLUIDS & ELECTROLYTES, One Week, March 28
THORACIC SURGERY, One Week, March 28
VAGINAL SURGERY, One Week, May 9
BASIC INTERNAL MEDICINE, One Week, April 25
BASIC ELECTROCARDIOGRAPHY, One Week, March 14
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates
OBSTETRICS, General & Surgical, Two Weeks, April 18
PAIN RELIEF IN CHILDBIRTH, Three Days, April 13
CLINICAL USES OF RADIOISOTOPES, Two Weeks, April 25

Information concerning numerous other continuation courses available upon request.

TEACHING FACULTY
Attending Staff of
Cook County Hospital
Address: REGISTRAR, 707 South Wood Street
Chicago, Illinois 60612

underachievers

A residential facility for Junior and Senior High School males who need psychiatric help with: ■ Problems of academic underachievement and attendance . . . ■ Difficulties in family-school-social adjustments.

Complete academic and therapy program for grades 7 through 12.

For information contact: Rita Burgett, Secretary
The Readjustment Center
Box 373, Ann Arbor, Mich.
Phone: (AC 313) 663-5522



Meeting Memos



February 18-19—A two-day Educational Institute "Toward Therapeutic Long-Term Care" will be held at the Sheraton-Chicago Hotel. It will be sponsored by the Illinois Nursing Home Foundation and the Kramer Foundation and conducted by the Kramer Foundation staff.

Registration is open to anyone in these fields and will be limited to the first 50 who register. The registration fee of $60.00 covers the two-day Institute, coffee breaks and reading material to be sent to the registrants prior to the first meeting. Further information may be obtained from Mr. Ross Reardon, Executive Director, Illinois Nursing Home Association, 118 Peoria Street, Washington, D.C.

February 21-25—The American College of Physicians will present its Postgraduate Course No. 12, "Cancer for the Internist," at Presbyterian-St. Luke's Hospital, Chicago.

The course will cover basic scientific and clinical aspects of cancer for the internist in the diagnosis and treatment of the cancer patient. It will include the mechanism of action of radiation and chemotherapy, and practical aspects of the biochemistry of growth. The role of the surgeon, the pathologist, the radiotherapist and the biochemist, together with the internist in the multiple disciplinary management of the cancer patient will be presented. Practical clinical chemotherapy for malignant disease offering worthwhile benefit will be adequately covered.

The fee for ACP members is $60, for nonmembers it is $100. Registration forms and requests for information should be directed to Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

2 Approved Group Insurance Plans

for members of

THE ILLINOIS STATE MEDICAL SOCIETY

GROUP DISABILITY PLAN

TOTAL DISABILITY CAN BE COSTLY
Review Your Needs Today
Amounts Available up to
$250.00 Weekly

SPECIAL FEATURES

- SICKNESS BENEFITS TO AGE 65 PLAN
- THREE EXCELLENT PLANS TO CHOOSE FROM
- CONVERSION PLAN AVAILABLE AT AGE 70
- LOW RATES UNDER A TRUE GROUP POLICY

GROUP MAJOR MEDICAL PLAN

$15,000 MAXIMUM BENEFIT

Choice of 2 Deductibles

Dependent Coverage Available

Both IN and OUT of Hospital Expenses Included

Truly Catastrophic Protection

GROUP POLICY RATES

CALL OR WRITE

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance
ADMINISTRATORS

9933 LAWLER AVENUE SKOKIE, ILLINOIS PHONES 679-1000

Nervous
Geriatrics

Long Term and Short Term Care



Est. 1909

Mental
Custodial

Day Care and Mental Health Clinic

RESTHAVEN

This modernly equipped institution located in the beautiful Fox River Valley 35 miles west of Chicago, cooperates with physicians to the fullest extent.

It provides accommodations for 100 patients in single and double rooms. Resthaven accepts patients by referral and direct admission.

RESTHAVEN HOSPITAL, 600 VILLA ST., ELGIN, ILL.
Phone: SH 2-0327

Northwestern University Studies Learning Disorders in School Children

Northwestern University recently began a study of 10,000 Chicago-area school children to gather more precise information on the relationship between learning difficulties and minor brain damage.

"Our previous research suggests that as many as five percent of elementary school pupils from average family backgrounds have difficulties in learning how to read, write and solve problems because of undetected brain damage," said Helmer R. Myklebust, director of Northwestern's Institute for Language Disorders and a co-director of the study.

Goals of the study will be to refine these preliminary statistics, develop methods to assist teachers in recognizing students hindered by brain damage, and improve general diagnostic techniques, Myklebust said. Some 5,000 third graders and an equal number of fourth graders, selected at random from Chicago and surburban schools, will be examined in the project.

The three-year study will be financed by a $265,000 grant from the Division of Neurological and Sensory Diseases of the U.S. Public Health Service.

The other study director will be Dr. Benjamin Boshes, chairman of the department of neurology and psychiatry of the Northwestern School of Medicine. Also participating will be physicians in the Medical School's pediatrics and ophthalmology departments and professors from the School of Education and the department of psychology in the College of Arts and Sciences.

February Clinics for Crippled Children

Clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will hold general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical social, and nursing service. There will be special clinics for children with cardiac conditions and rheumatic fever, and for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

The February Clinics are:

February 16 Chicago Heights General—St. James Hospital

February 17 Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

February 17 Rockford — St. Anthony's Hospital

February 17 Bloomington — St. Joseph's Hospital

February 17 Elmhurst Cardiac—Memorial Hospital of DuPage County

February 22 Peoria — Children's Hospital

February 23 Springfield Cerebral Palsy (P.M.)—Memorial Hospital

February 23 Aurora — Copley Memorial Hospital

February 25 Chicago Heights Cardiac—St. James Hospital

Hospitalization For Emotionally Disturbed Patients

- MERCY HOSPITAL, Urbana, Ill., a not-for-profit general hospital, offers a Completely Modern, 30-bed Psychiatric Unit.
- The Unit is an evaluation & intensive treatment center, not intended for the care of the incurably mentally ill.
- It is equipped to offer more Intensive Care at Less Expense, Quickly Available Care, a Consultative Staff in Many Specialties, and has three Board-Qualified Psychiatrists on the Staff.
- All Physicians, staff and non-staff are invited to make psychiatric referrals.

For information concerning admission:

PSYCHIATRIC UNIT—MERCY HOSPITAL
1412 West Park Street, Urbana, Illinois
Area Code 217—Ph. 367-6621 Ex. 513

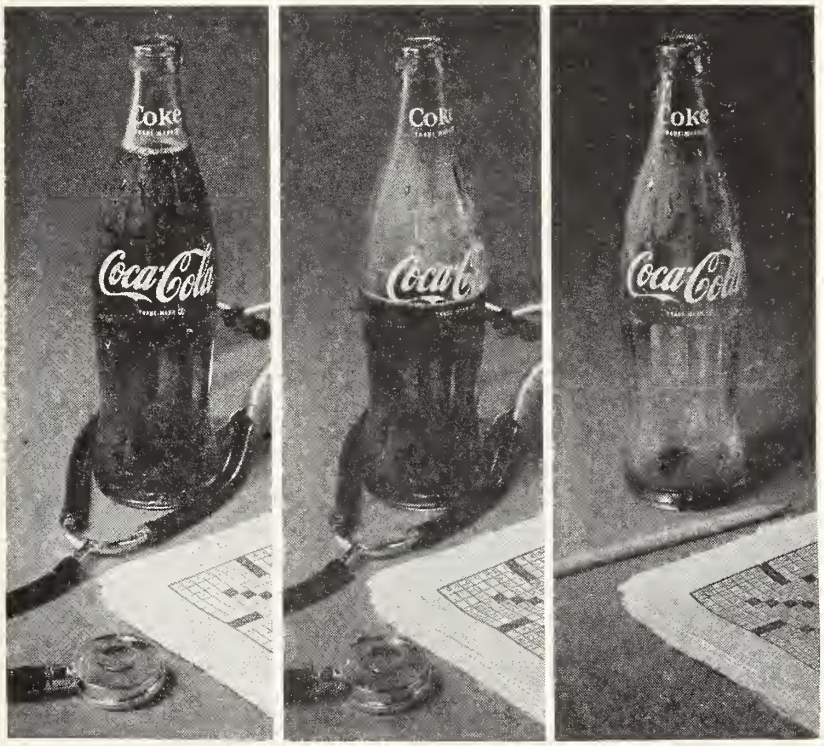
Forest Hospital

is an intensive care facility noted for its advanced, comprehensive treatment programs. One such program is the adolescent service, which provides psychotherapy for girls and boys from 13 through 17. Accredited school facilities are on campus. Parents of children in treatment receive therapy and social work follow up. A game room, swimming pool, recreational activities are offered in a total setting designed to speed recovery. A psychiatrist specializing in adolescence is in charge.

555 Wilson Lane
Des Plaines, Illinois
Dial 827-8811

Adolescent Program,
Dr. Daniel Schiff, Director

This is one in a series of advertisements describing some of the services offered at the hospital.



11:47 pm **11:53 pm** **12:06 am**

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke TRADE-MARK®

OBITUARIES

ROBERT S. BERGHOFF*

1889-1965

Robert Sixtus Berghoff, M.D., was born in Fort Wayne, Indiana on June 9, 1889 and, after a long illness, died December 26, 1965 in Chicago. He was the son of Mr. and Mrs. Herman J. Berghoff. His father was the founder of the famous Berghoff brewery in Fort Wayne and of the well-known Berghoff's Restaurant in Chicago.

Dr. Berghoff attended St. Ignatius High School and College in Chicago, graduated from St. Louis University School of Medicine in 1913 with a B.S. and an M.D. degree, and took a rotating internship at St. John's Hospital in St. Louis, 1913 to 1914. After his internship he took postgraduate work at Harvard University Medical School and at the Mayo Clinic in Rochester, Minnesota, then studied in Vienna. Upon his return from Austria he became a member of the Rush Medical College faculty and the Presbyterian Hospital staff.

In 1917 he was commissioned a captain in the Medical Corps of the United States Army and served at Camp Grant, Illinois and Camp Bowie, Texas. He was discharged with the rank of major in 1919 and served in the medical reserves from 1925 to 1930.

In 1919 he returned to Presbyterian Hospital and Rush Medical College and later became associated with Mercy Hospital and the Mercy Free Dispensary as attending physician. In 1947 he served Mercy Hospital as president of its staff.

Dr. Berghoff was certified by the American Board of Internal Medicine, he was a fellow of the American College of Physicians, a member of the Chicago Society of Internal Medicine, the American Heart Association, the American Trudeau Society, the Chicago Medical Society, the Illinois State Medical Society and the American Medical Association. His book, "The Most Common Forms of Heart Disease," was used as a text in many medical schools; he was the author of many scientific articles which appeared in leading medical journals. As chairman of the Scientific Service Committee and the Postgraduate Medical Education Committee of the Illinois State Medical Society, he helped to provide postgraduate training for members of his society and personally conducted many heart clinics throughout the state. He also served as clinical professor of internal medicine at Stritch School of Medicine, Loyola University.

He had the unusual distinction of serving his state medical society twice as its president. Dr. G. W. Post, president in 1944, died in office, and Doctor Berghoff, first vice-president at the time, completed his term of office. Then in 1946-1947, he served his own elected term as president of the Illinois State Medical Society.

Dr. Berghoff took time from his busy professional life to perform many civic duties. He served on the Board of Trustees of Blue Cross from its inception until his death. He gave unselfishly of his time and talent as a member of the Board of Education of Chicago from 1947 to 1957. He was vice-president of the Hoosier Society and a member of the Alpha Kappa Kappa Medical Fraternity. He took an active part in politics, worked diligently for the Sisters of Mercy at their Infirmary on Belmont Avenue, as well as at Mercy Hospital and throughout the Chicago diocese.

He is survived by his widow and several brothers.

Arkell M. Vaughn, M.D.
Past President, ISMS

Hardin E. Coen*, Chicago, died December 26, aged 61. A graduate of Rush Medical College in 1931, he specialized in internal medicine.

Tadeus Dundulis*, Chicago, died December 13, aged 80. A graduate of Chicago Medical School in 1929, he specialized in obstetrics and gynecology.

Frederick F. Garrison*, Aurora, died December 19, aged 90. A graduate of Rush Medical College in 1904, he retired in 1957. He was an honorary staff member of the Aurora hospitals.

Jacob A. Goodman*, Chicago, died January 11, aged 76. A graduate of Northwestern University Medical School in 1912, he retired in 1962. He had been

(continued on page 201)

on the staff of Mercy and Edgewater hospitals. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Kenneth J. Hebenstreit*, Chicago, died November 15, aged 63. He was a graduate of Loyola University School of Medicine in 1930.

Curtis Henderson*, Clay City, died December 25, aged 85. A graduate of Chicago College of Medicine & Surgery in 1912, he retired in 1964. He was on the staff of Clay County and Richland Memorial hospitals. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Homer L. Hiles*, Villa Park, died January 7, aged 60. A graduate of Hahnemann Medical College & Hospital of Philadelphia in 1931, he specialized in occupational medicine.

Alex J. Jablonowski*, Chicago, died January 2, aged 52. He was a graduate of Chicago Medical School in 1943.

Warren Johnson*, Chicago, died December 26, aged 86. He was a graduate of the University of Illinois College of Medicine in 1909. He was a member of the Fifty Year Club and an emeritus member of ISMS.

Calvert H. Lane*, Chicago, died December 17, aged 76. He was a graduate of Northwestern University Medical School in 1919.

John A. Marszalek*, Chicago, died December 14, aged 79. He was a graduate of Loyola University School of Medicine in 1929.

Arthur E. Miller*, Chicago, died July 5, aged 73. A graduate of Chicago Medical School in 1921, he specialized in general surgery and internal medicine.

Franklin J. Moore, Sr.*, Chicago, died December 14, aged 52. A graduate of Rush Medical College in 1937, he specialized in pathology. He was director of clinical and anatomic pathology at Little Company of Mary hospital, board member of the Illinois division of the American Cancer Society, vice president of the Chicago Pathological society and member of various other medical organizations.

Gervaise P. Pallasch*, Chicago, died January 7, aged 62. He was a graduate of Chicago Medical School in 1940.

Harry J. Parker*, Chicago, died January 7, aged 57. A graduate of Loyola University School of Medicine in 1938, he specialized in dermatology.

Anthony V. Partipilo*, Chicago, died January 5, aged 66. A graduate of Loyola University School of Medicine in 1925, he specialized in general surgery. Former president and chief of surgery of St. Francis Xavier Cabrini hospital, he was a staff member of Columbus hospital. Professor of surgery, he was honored in 1963 as outstanding alumnus of Stritch School of Medicine.

Augustin Pribyl*, Berwyn, died December 4, aged 48. A graduate of Fakulta Vseobeckeno Lekarstvi Universita, Katerinska, Praha in 1947, he specialized in ophthalmology.

Alexander M. Rackus, Chicago, died October 9, aged 72. He was a graduate of Chicago Medical School in 1922.

Alvin F. Restarski*, Chicago, died July 29, aged 54. A graduate of Loyola University School of Medicine in 1936, he specialized in ophthalmology and otolaryngology.

Robert E. Shea*, East St. Louis, died December 11, aged 50. He was a graduate of St. Louis University School of Medicine in 1941.

Samuel Shnaper, Park Ridge, died December 13, aged 63. He was a graduate of Northwestern University Medical School in 1928.

Karl L. Vehe*, Chicago, died December 30, aged 77. He was a graduate of Northwestern University Medical School in 1915.

Arthur M. Weiss*, Chicago, died November 26, aged 58. A graduate of Chicago Medical School in 1932, he specialized in obstetrics and gynecology.

Frank Wright*, Chicago, died January 3, aged 89. A graduate of Northwestern University Medical School in 1904, he specialized in internal medicine. He was a member of the Fifty Year Club of ISMS.

**Indicates member of Illinois State Medical Society.*



a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).

Your Advertisers

IMJ

Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you and your Society to mention your Journal when writing them.

CLASSIFIED 204

EQUIPMENT

Sanborn Division Hewlett-Packard Co., Waltham, Mass. 179

FOOD

Coca Cola Company, Atlanta, Ga. 199

Grocery Store Products Co., West Chester, Pa. 195

INSURANCE

Medical Protective Company, Ft. Wayne, Ind. 193

Parker, Aleshire & Company, Skokie, Ill. 197

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Ill. 121-124, 169-172

Ames Company, Elkhart, Ind. 114

Burroughs Wellcome & Co., Tuckahoe, N. Y. 118

Endo Laboratories, Garden City, N. Y. 117

Lederle Laboratories, Pearl River, N. Y. 184-185, Third Cover

Eli Lilly and Company, Indianapolis, Ind. 126

The S. E. Massengill Co., Bristol, Tenn. 177

Wm. S. Merrell Company Div., Richardson-Merrell, Inc., Cincinnati, Ohio 104-105, 175

Parke, Davis & Company, Detroit, Mich. 183

A. H. Robins Inc., Richmond, Va. 109-111

Roche Laboratories Div., Hoffmann-LaRoche, Inc., Nutley, N. J. Fourth Cover

J. B. Roerig Div., Chas. Pfizer & Co., New York, N. Y. 173

G. D. Searle & Company, Chicago, Ill. Second Cover

Smith Kline & French Laboratories, Philadelphia, Pa. 125

U. S. Vitamin & Pharmaceutical Corp., New York, N. Y. 119-120

Wallace Laboratories, Cranbury, N. J. 101, 115, 186-187

Warner-Chilcott Laboratories, Morris Plains, N. J. 112-113

Winthrop Laboratories, New York, N.Y. 102, 181

SANATORIA AND INSTITUTES

Forest Hospital, Des Plaines, Ill. 199

Mercy Hospital, Urbana, Ill. 198

Norbury Hospital, Jacksonville, Ill. 201

North Shore Hospital, Winnetka, Ill. 193

The Readjustment Center, Ann Arbor, Mich. 196

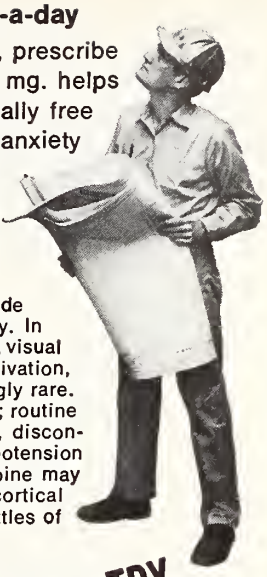
Resthaven Hospital, Elgin, Ill. 197

SERVICES

Cook County Graduate School of Medicine, Chicago, Ill. 196

Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

THE SQUIBB TRANQUILIZER

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB

Squibb Quality — the Priceless Ingredient

IMJ

Illinois Medical Journal

CONTENTS

volume 129, no. 3 *March, 1966*

MEDICAL PROGRESS

Liver Functions in Clinical Medicine, Conclusion
Frederick Steigmann, M.D., Chicago.....233

CLINICAL ARTICLES

Absenteeism in Industry
David Joe Smith, M.D., Chicago.....225
A Prolonged Acting Topical Nasal Decongestant for Various Rhinitides
Peter S. Mayer, M.D., Chicago.....230
Sarcoidosis and Rheumatoid Arthritis
William R. Thompson, M.D. and George W. Ferenzi, M.D., Chicago.....239
Non-Diabetic Ketosis in Diabetes During Late Pregnancy
Hugo R. Rony, M.D., Chicago.....243
Patients Refusing Psychiatric Care
David W. Swanson, M.D., Geneva.....247
Cytoxan Treatment of Kaposi's Idiopathic Hemorrhagic Sarcoma
Malcolm C. Spencer, M.D., Danville.....252
Thoughts on Psoriasis
William G. Parker, M.D., Mount Vernon.....256
Paraldehyde Acidosis Syndrome
Raimonds J. Gailitis, M.D., Chicago.....258
A Profile of Dr. Hirsch as a Humanist
Samuel A. Levinson, M.D., Chicago.....263
The View Box
Leon Love, M.D., Chicago.....267

FEATURES

President's Page 220
Editorials 269
Doctor's Library 278
Dr. SIMS in Action.....282
Placement Service 286
IMAA Reports 289
New Pharmaceutical Specialties.....291
℞ Reviews 293
News and Announcements.....295
New Regulations Over Depressant and Stimulant Drugs.....297

Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Ill. 60601. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.50 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies available at cost of 75 cents. Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.
Copyright 1966, The Illinois State Medical Society.

anytime you see a cold coughing

coughing

it the cough as well as the cold

ycomine® Syrup

teaspoonful (5 cc.) contains:

dan®		
drocodone bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming)		
matropine methylbromide	1.5 mg.	
amine maleate		12.5 mg.
ylephrine hydrochloride		10 mg.
onium chloride		60 mg.
um citrate		85 mg.

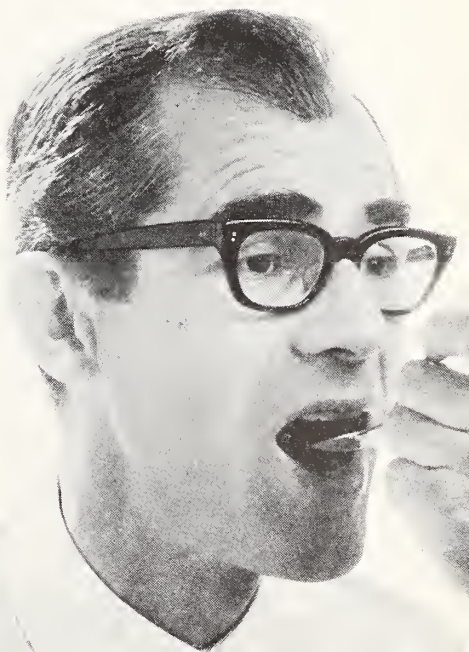
methylparaben 0.13% and propylparaben 0.02% as ervatives)

a highly palatable cherry-flavored vehicle

its both productive and nonproductive h, without suppressing productive cough • ngests the airways • liquefies secretions responsible for irritation • provides prompt symptomatic relief of allergic symptoms • is well tolerated • rarely causes constipation

Average Dosage: Adults, 1 teaspoonful after meals and at bedtime with food. Children 6-12 years, ½ teaspoonful; 3-6 years, ¼ teaspoonful; 1-3 years, 10 drops; 6 months to 1 year, 5 drops. Administer after meals and at bedtime with food.
On oral Rx where state laws permit.

Caution: Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.



do®
ENDO LABORATORIES INC.
Garden City, New York.

U S Pat 2 630 400

The president's page



Burtis E. Montgomery, M.D.

APRIL LEADERSHIP CONFERENCE

VITAL TO OUR EXISTENCE

One of the ways in which the Illinois State Medical Society serves its members is by providing them with scientific, political and socio-economic information that will help them to function most effectively in their chosen profession. In fact, dissemination of such information is the principal purpose of any medical organization; communication being our reason for existing as a society. How many of us, though, stop to consider that information does not "just happen" or flow spontaneously. Behind any meaningful communication is an organization inspired by men who are either born to leadership or have it thrust upon them.

The history of medicine—and the source of its strength and progress—in the United States is one of organization, behind which knowledgeable individuals are dedicated to working for the good of the whole. Upon these individuals or leaders—most of whom were elected to their roles rather than being born to them—the rest of us depend for guidance on some pretty important matters.

Because the actions and decisions of our leaders may affect our lives and livelihoods, it is imperative that those we elect become quickly informed about the apparatus known as organized medicine. With this in mind, the Board of Trustees of your State Society has planned a two-day leadership conference for April 27-28 in Springfield. The program is packed with subject matter pertinent to every office now held by an Illinois doctor. Every county medical society should plan to have in attendance its president, president-elect, secretary, executive secretary and such key committee chairmen as Public Affairs, Legislation, and Bulletin editor. In addition, those men not now in office but considered potential leaders should be encouraged to attend this conference.

The program material will range from such nuts and bolts workshops as "How to prepare a resolution for the House of Delegates" to the philosophical realm of "the elements of leadership." Speakers will include such outstanding figures as Milford O. Rouse, M.D., Speaker of the AMA House of Delegates, and John W. Cashman, M.D., Chief of the Division of Medical Care for the Department of Health, Education and Welfare.

When you receive direct word from our secretary, Dr. Jacob E. Reisch, regarding this conference, take action immediately. Your attendance is not only vital to the future of your profession but can be a rewarding personal experience.

Editor's Note: Additional information about the Conference appears on page 287 in this issue of the Journal. As a reminder of the date and place we suggest that County Society officers tear the page out for their April meeting file.

IMJ

Illinois Medical Journal

volume 129, number 3 March, 1966

Absenteeism in Industry

David Joe Smith, M.D./chicago

For an employee to call in and report off work when he is ill is standard procedure in many businesses and industries. It took place at United States Steel's South Works in Chicago more than 7000 times last year —and resulted in 84,000 man-days of work absence.

Our company is interested in its non-occupational illness-absence experience because of its effects. Absence slows production; reduces quality; increases waste and spoilage; impairs service; complicates administration; and adversely affects morale if unexpected, frequent, or prolonged. Absence inflates direct operating and administrative costs as well as related fringe benefits. Absence is expensive.

Presented here is our approach to the study of absence from work for medical reasons and a review of experience in two quite different work settings.

Plant Medical Director, South Works, United States Steel.

The key to acquiring a comprehensive knowledge of personal illness-absence is having each employee who becomes ill at work or who returns to work after being out ill, "clear" through the medical department. Here, among the many values of the person to person contact between nurse or doctor and the employee, such knowledge begins.

If the employee is sent home from the medical department, his reason for absence is apparent from the beginning. For other medical absences the causes are determined at the times of return. They may be obtained from the employee; directly or indirectly from his personal physician; and from observation and examination. The occasional short absence for ordinary reasons is not challenged. If the absence is repeated, prolonged or serious, however, a physician's release with guiding information is required. Rarely if ever is such an employee returned to work without his attending physician's release. In some

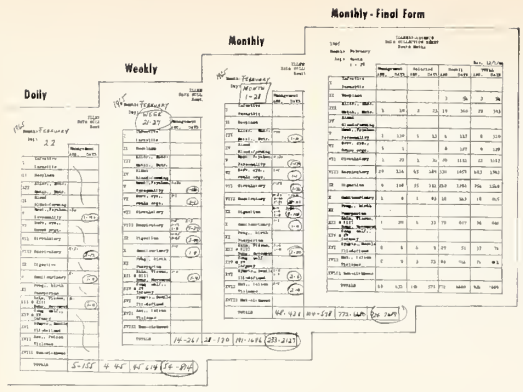


Figure 1

cases, however, for reasons peculiar to his job or work environment it is necessary to delay his return. The immediate need is to determine the employee's readiness to return to work. The primary objective of a return to work medical procedure is to establish the employee's ability to meet the physical and psychological demands of his job—to function effectively and safely, both for himself and others.

A very important by-product, however, is the accumulation of absence data which this procedure affords.

Visits to our medical department for non-occupational reasons are recorded on an individual cumulative health record. The entries are dated, and for absences from work include the date of the last day worked, the reason for absence, the treatment given, the condition of the employee on return to work, and an indication of his ability to do work. The health records for each twenty-four hour period are reviewed by a physician before being filed.

Data Collection

Data collection begins as the physician reviews the records. Absences are recorded on a daily tally sheet by entering the number of days of each absence in the appropriate block, corresponding to the cause of the absence and the employee group from which the absentee comes (Figure 1). The causes of absence are taken from The International Statistical Classification of Diseases, Injuries, and Causes of Death of the World Health Organization;[1] and there are three employee groups—management, salaried, and hourly. The data from the daily sheet are consolidated on a weekly sheet; the weekly data on a monthly sheet; and at the end of the year an annual tabulation is made. Reports to management are submitted monthly.

By correlating these data with the number of employees on the roll and the number of work turns scheduled, certain measurements of absence are calculated. These are the Frequency Rate (number of absences per employee in the period); the Severity Rate (the number of days lost per absence); the Disability Rate (the days lost per employee in the period); and the Ineffective Rate (percent of work time lost). These, too, are reported at the end of each month and are included in the annual report.

One of our problems is how to "count" absence. Many of our plant facilities operate around the clock, seven days a week. Workmen rotate on the three daily turns or shifts; work a four or five or even six-day week; work different days in the week; may or may not work on a holiday; often take vacation time concurrent with sick-time; and so on *ad infinitum*. An exact determination of the number of scheduled work turns missed is nearly impossible to obtain—and the attempt is prohibitive in time and effort required. For these reasons we have been recording *calendar* days missed, counted from the date of the last day worked to the day of release for work by the medical department. Since this ignores turns and days an individual would not have been sched-

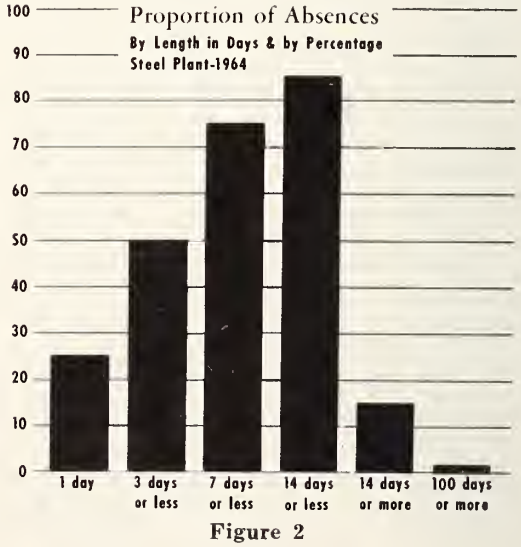


Figure 2

uled to work, there are built-in errors in the method. But these errors are consistent and therefore of no consequence within the plant, and the method does have the advantage of being accurate and reproducible. We recognize that there is a tendency for our figures to be "loaded" against us when compared to those from other sources, but such comparisons can be made if done with caution.

When this procedure has been followed, the data collected, and the calculations made, the medical department and interested management have a "handle" on the non-occupational illness-absence of the plant. They know what has gone on in the past, have a perspective on current experience and a reference point or baseline for the future. Here, also, they find a useful tool for measuring the impact of various influences on plant experience.

Eleven Days Are Average

We have found that over-all absence for personal medical reasons runs about three percent of scheduled time. There is less than one absence per employee per year; but if all the days absent are averaged across the plant population, there are eight days of absence per employee. The average length of the absences which do occur is eleven days.

Most absences are of short duration (Figure 2). In fact, roughly one-fourth of them last only one day. About one-half

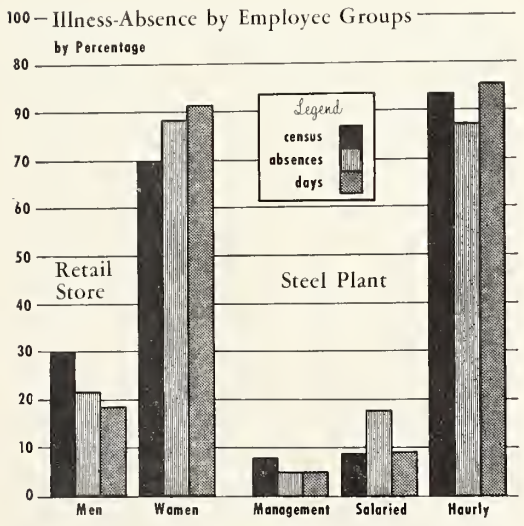


Figure 4

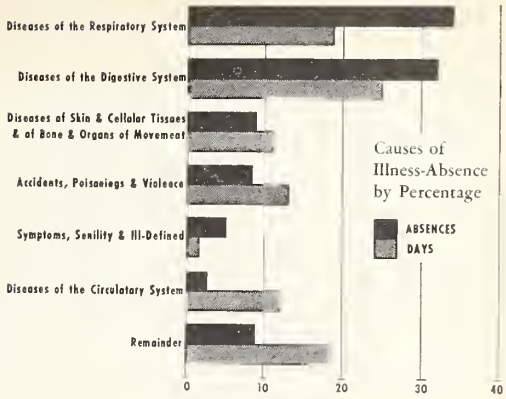


Figure 3

are of three days or less, and three-fourths are no longer than a week. Herein lies the fallacy of studies which report only on absences of "more than three days" or "longer than a week." The "iceberg" phenomenon in this instance is quite evident. We find that not more than twenty-five percent of our absences are longer than one week. "Extended" absences—those of one hundred or more days—occur only once in one hundred times.

Diseases of the respiratory tract and of the digestive system combined cause more than one-half of all the absences and nearly one-half of the days absent (Figure 3). The combination of accidents, poisonings and violence, and that of diseases of the skin, tissues and bones each accounts for another ten percent of the absences. Several lesser causes make up the remaining thirty percent.

Certain employee groups are responsible for more than their proportionate share of absence (Figure 4). For example, the ladies are absent more often and remain away longer than the men. Likewise, non-exempt salaried employees are absent more than management and hourly people. At times there are many new people in the work force, most of them young. At one time their absence rate was quite low, at least until the end of the probationary period. More recently, however, we have noted immediate, repeated and even prolonged absence among them. This is disturbing both for the present and for the future, as we have found that a pattern once established is very likely to continue.

While most of our experience is from many people missing a few days, in any

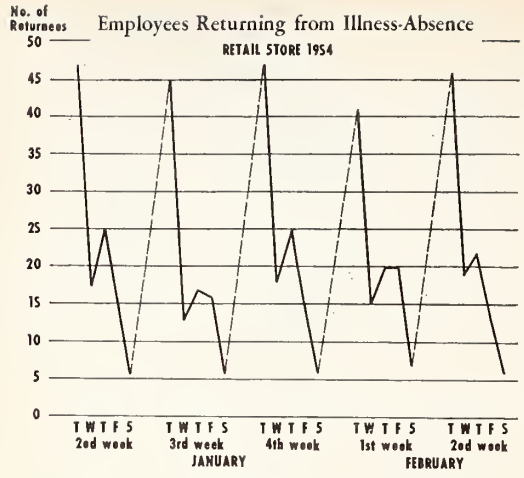


Figure 5

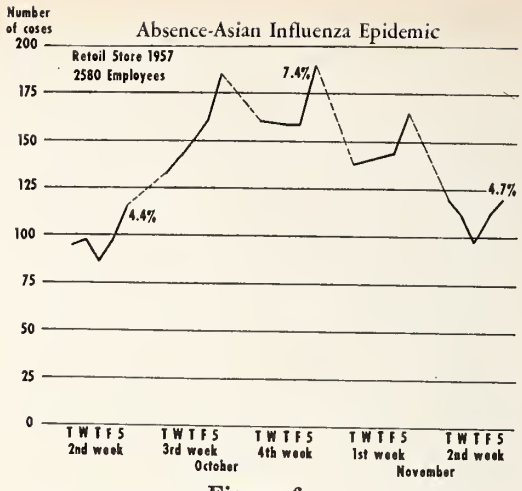


Figure 6

large group there are those individuals who seem to be "illness-prone" or at least to miss work more often and for longer periods than their fellow workers. In the procedure we have outlined these people can be discovered and identified, sometimes from the "paper profile" their pattern of absences makes on the health record. Among this group are the alcoholics, who average four weeks of absence compared to the annual plant-wide figure of eight days. Their frequent absences, often unexplained, usually as extensions of days off, increasing in length and with a progression of diagnoses attributable to the effects of excessive drinking, give them away. This procedure which "spots" them also gives the nurse or doctor a chance to follow the progress of their illness.

Compare these experiences at our South Works plant to those in a previous work location (a large department store) where there was a fixed daylight schedule and a five day work-week. The medical department there received daily reports of absence from all other departments with absentees listed by name, payroll number and reason for absence. This enabled us to maintain a file of those out ill on a day-by-day basis, and to know at any time who was out, how many were out and for how long. We decided to plot daily on a large graph the number of employees out ill and the number returning to work after illness (Figure 5). *Mirabile dictu*—immediately there emerged an almost electrocardiogram-like weekly pattern of returnees: many the first day—fewer the second—more the third—less the fourth—and few if any the last day of the week. Seldom were there gross changes. Then over a six year period there developed variations in the pattern of absence with the weather, and the season and with economic conditions. Generally speaking, the better the weather, the better the attendance; the better the economy, the poorer the attendance. When both good weather and a good economy were present, the economic influence prevailed.

Vaccine and Absences

One interesting sidelight to this observation of experience by graph—it helped us to "see" what went on in our organization during the Asian Influenza epidemic in 1957. At this time we are neither endorsing nor advocating the general administration of "cold" or "flu" vaccine within industry. But in 1957 there was a pandemic, the specific agent was known and specific protection was available—so we used it. We were able to show (Figure 6) that from a normal seasonal level of four and one-half percent our absence rate rose, was never over seven and one-half percent and fell to pre-epidemic levels without event. And this was accomplished with a rate of significant reaction to the vaccine of one-half of one percent.

Now that we have interviewed, examined, observed, recorded, tabulated and reviewed as described here, over a considerable period of time, in both a manufacturing and a retail setting, we think we have learned enough to reach some working conclusions.

Our South Works plant is a sizable "village." We have learned that in due time almost any diagnosis can be found there and its impact felt. Acute illness, chronic disease, destructive and degenerative disorders are to be seen among our employees; and accidents and injuries occur to them. That these things have a profound effect on our illness-absence experience is firmly established.

But we have also learned that not all illness-absence can be explained by medical chance alone—that other factors and influences must be operating. The American Medical Association's Syllabus on Work Absence begins with this statement: "A worker on the job must be both willing and able to be there; if one of these conditions is not satisfied, he will be absent."[2]

A Chicago daily newspaper reported not long ago that a director of the National Association for Mental Health said in a speech that perhaps fifty percent of work absence is for psychological causes.[3] We are also convinced that personal, social and economic factors rank with disability in the production of illness-absence.

We believe that by inspection, observation and examination procedures the employee can be helped to know and understand his health status. There are many indications that this is a valid assumption.

We believe that through counselling and health education the employee can be motivated to seek out and use competent medical care for the correction of remedial defects, the control of chronic disease, and the surveillance of progressive, degenerative or destructive disorders. The numerous hernias repaired, the cases of diabetes and hypertension brought under control, and the occasional more serious case worked up and successfully rehabilitated (after discovery in and referral from the plant medical department) give support to this belief.

We believe that in the course of such endeavors the employee will be guided to a more wholesome attitude toward health and work, and will be encouraged to contribute not to absenteeism but to "presenteeism." We would hope to reach particularly the fifty percent who absent themselves from work for illness other than organic disease. There is some evidence that this is not a vain hope.

In summary—we support a vigorous, comprehensive occupational health program employing recognized preventive and constructive health measures, believing that it can make positive contributions to employee and employer alike, and will result in an improved industrial illness-absence experience.

To this end we are gathering data to reflect what is being done, to guide us in our future course and to help us convince management that increased support of such a program is sound business practice and a wise investment.

References

1. *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death*, 1955 revision, Geneva, Switzerland: World Health Organization, 1957, Vol. 1 and Vol. 2.
2. Blumberg, M. S., and Coffin, J. A.: A Syllabus on Work Absence, *Arch. Industr. Health* 13: 55-70, 1956.
3. *Chicago Tribune*, February 21, 1965.

Mark Your Calendar Now

ISMS 126th ANNUAL CONVENTION

May 15-18, 1966 ***Sherman House, Chicago***

A Prolonged Acting Topical Nasal Decongestant For Various Rhinitides

Peter S. Mayer, M.D./chicago

In the practice of internal medicine, complaints of nasal congestion are a common occurrence. The method of treatment varies, but topical therapy is preferable because it is rapid and less apt to produce systemic by-effects. However, the preparations available for local use have been disappointing from the standpoint of efficacy, tolerance, and in many instances, side reactions.

To serve the desired ends both safely and effectively, a preferred topical nasal decongestant should have the following qualities: (1) prolonged action for minimizing frequency of use; (2) freedom from irritants; (3) no associated tachyphylaxis; (4) minimal systemic action and side effects; (5) absence of tendency toward rebound; (6) predictable action.

We believe the new topical nasal decongestant used during the study to be reported herein closely approaches these necessary and desirable properties. The preparation was examined from the standpoint of effectiveness, duration of action and possible side effects.

Pharmacologic Data

This new nasal decongestant, oxymetazoline hydrochloride (Afrin®, product of Schering Corporation, Bloomfield and Union, New Jersey) is a sympathomimetic agent belonging to the imidazolines. Studies indicate it has a broader therapeutic index than standard sympathomimetic agents used as topical decongestants and has a more prolonged pharmacologic activity than any of the other compounds in its group. Moreover, it produces the desired therapeutic response in very low concentrations (1:2,000). Oxymetazoline acts by selective local vasoconstriction. Studies in animals showed that it did not produce irritation, even when applied to the conjunctiva of rabbits. Clinical studies here and abroad have demonstrated its safety and efficacy.[1-14]

Methods

From a large number of patients seen in the practice of internal medicine, 51 people were selected for treatment with oxymetazoline. Of these, 13 were male patients and 38 were female. The average age was 36 years, and the range was from 12 to 66 years. Prior to administration, patients were examined thoroughly for local pathology. During administration they were observed for possible local and systemic side effects.

Diagnostic categories were coryza, sinusitis, vasomotor rhinitis, and upper respiratory infection. About two-thirds of the group suffered acute conditions or acute exacerbations, while the remainder had problems which were chronic in nature.

Spray was used by 21 patients and drops were used by 29. Administration was usually twice a day. In the group of 51, there were 25 patients who were known to have repeated the instillation fifteen minutes after the initial one.

Onset and duration of action, subjective comments, and objective observations were

recorded. Criteria for rating were: excellent, good, fair, or poor. *Excellent* indicated reasonably rapid onset, a duration of eight hours, and absence of undesirable effects. *Good* responses were similarly evaluated except that the duration of effect was four to six hours. *Fair* indicated a slightly reduced onset and duration, or a mild unwanted effect. A *poor* response indicated possible side effects or a duration of less than two hours.

Results

The degrees of relief obtained in this group are shown in Table I. Of 51 patients, 42 (82%) obtained satisfactory results. All of the patients with sinusitis achieved excellent results.

More than three-quarters of the subjects experienced onset of action within fifteen minutes. The duration of action was more than twelve hours in 13 patients and more than eight hours in 19 patients. Thus, 32 of the 51 obtained relief for at least eight hours from a single instillation. Improved ability to sleep, because of decongestion, was mentioned in 25 instances.

There were no central nervous system effects, none of the patients developed tolerance, and rebound engorgement did not occur. Discontinuance was necessary in only two cases. One patient experienced nausea with vomiting, and the other, a persistent sneezing and rhinorrhea. Both of these patients were using drops. There were two complaints of mild stinging of the nasal mucosa, but this did not require discontinuance of the preparation.

It may be of some interest that one of the patients in the study was diabetic and another asthmatic. Both of them experienced excellent results without any unwanted effect.

Case Reports

The following reports on the treatment of individual patients are typical of the total experience with oxymetazoline among this group of patients.

Case 1. A 35-year-old woman with chronic vasomotor rhinitis was given oxymetazoline drops twice daily. Action was noted within fifteen minutes, and decongestion lasted more than twelve hours after each instillation.

The patient was able to sleep well because of her relief, and there was objective decrease of mucosal edema. She was particularly impressed with the rapid onset of action.

TABLE I

RESULTS BY DIAGNOSIS

Diagnosis	RESULT				Total
	Excellent	Good	Fair	Poor	
Caryza	13	..	1	2	16
Sinusitis	6	..	..	..	6
Vasomotor rhinitis	10	2	1	..	13
Upper respiratory infection	13	2	..	1	16
TOTAL	42	4	2	3	51

Case 2. A 59-year-old man had severe upper respiratory infection. There was marked injection of the nasal mucosa and purulent discharge.

Oxymetazoline spray was ordered twice daily. The patient experienced relief in fifteen minutes, lasting more than twelve hours. Decreased injection and discharge were notable.

Case 3. Seasonal exacerbation of vasomotor rhinitis caused a 40-year-old man to seek treatment. There was 3+ pallor of the nasal mucosa and bilateral congestion.

Oxymetazoline drops used twice daily produced relief within thirty minutes, and the response lasted more than eight hours. There was objective decrease in pallor and congestion.

The patient found oxymetazoline more effective than other preparations he had used, and described the drops as "wonderful."

Case 4. A 38-year-old woman was treated for acute coryza. She was given oxymetazoline spray to use twice daily.

Relief lasted more than twelve hours, and it began within minutes after instillation. Decrease in pallor and edema were observable.

Summary

Oxymetazoline hydrochloride (Afrin®) was given to 51 patients with nasal congestion. Diagnoses were varied, and ages ranged from 12 to 66.

Of the 51 patients included in the study, 46 achieved satisfactory results. The onset of action was very rapid, and relief was prolonged. Patients particularly noted an improved ability to sleep. Apparently, the compound very closely approaches the ideal nasal decongestant physicians are seeking —little or no rebound, low toxicity, prolonged action and rapid relief. No comparisons were made.

References

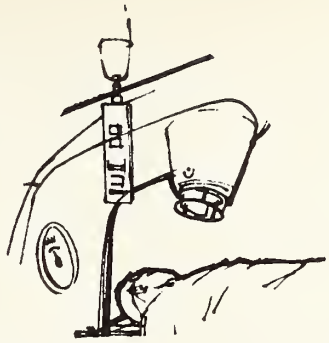
1. Eberhard, K. J.: Use of oxymetazoline in general practice. *The D.O.* 5:43-44, 1965.
2. Falkenberg. J.: Klinische Erfahrungen mit Nasivin [Clinical experience with Nasivin]. *Landarzt* 39:76-79, 1963.
3. Friedrich, R.: Behandlung der Rhinitis mit einem entzündungshemmenden Mittel [Treatment of rhinitis with an anti-inflammatory agent]. *Ärztliche Praxis* 15:1141, 1963.
4. Hladik, F.: Erfahrungen mit einem neuen gefässaktiven und schleimhautabschwellenden Präparat [Experience with a new vascular-acting and mucodecongestive preparation]. *Wiener med. Wchnschr.* 113:862-863, 1963.
5. Hotovy, R., and colleagues: Zur Pharmakologie des 2-(4'-tert. Butyl-2',6'-dimethyl-3'-hydroxybenzyl)-2-imidazolinium clorides [On the pharmacology of 2-(4'-tert. Butyl-2',6'-dimethyl-3'-hydroxybenzyl)-2-imidazolinium chlorides]. *Arzneimittel-Forschung* 11:1016-1022, 1961.
6. Kluger, H. A.: Erfahrungen mit einem neuen schleimhautabschwellenden und entzündungshemmenden Suspension für Nase und Augen [Experience with a new mucodecongestive and anti-inflammatory suspension for the nose and eyes]. *Hippokrates* 33:992-994, 1962.
7. Kuhnke, I.: Erfahrungen mit einem neuen schleimhautabschwellenden Mittel [Experience with a new mucodecongestive agent]. *Ärztliche Praxis* 13:2693- 2694, 1961.
8. Marx, J.: Augenarztliche Erfahrungen mit dem Vasokonstriktor Nasivin [Ophthalmological experience with the vasoconstrictor Nasivin]. *Wiener med. Wchnschr.* 113:586-587, 1963.
9. Miller, J.: Oxymetazoline in allergic rhinitis. *Clin. Med.* 71:1561-1564, 1964.
10. Miodek, J.: Erfahrungsbericht über Nasivin [Report of experience with Nasivin]. *HNO Wegweiser für die Fachärztliche Praxis* 10:92, 1962.
11. Obal, A.: Ein neues vasokonstriktorisches Mittel für die Ophthalmologie [A new vasoconstrictive agent for ophthalmology]. *Ärztliche Praxis* 14:2117-2120, 1962.
12. Polacsek, R.: Nasivin, ein neues Mittel zur Schleimhautabschwellung [Nasivin, a new agent for mucodecongestion]. *Hippokrates* 34:46-47, 1963.
13. Scheven, H.: Die Auslösbarkeit der allergischen Ophthalmoreaction as klinisches Kriterium für die Wirksamkeit vasokonstriktorischer Substanzen [The provocability of the allergic ophthalmic reaction as a clinical criterion of the effectiveness of vasoconstrictive substances]. *Klinische Monatsblätter für Augenheilkunde* 142:847-853, 1963.
14. Slodki, S. J., and Montgomery, C. A. Clinical comparison of oxymetazoline and ephedrine in nasal decongestion. *Current Therap. Res.* 7:19-21, 1965.

CHROMOSOMAL ANALYSIS

In general the clinical problems which need cytogenic chromosomal investigation include the following groups: 1) Individuals who are mentally retarded and also afflicted with other unrelated abnormalities; 2) Individuals in whom the phenotypic sex and chromosomal (genetic) sex do not correspond; and 3) Parents and siblings of the above group.

There is much to be done. Finer, more accurate techniques need to be developed for the study of chromosomes. The entire area involving congenital malformation and malfunction requires more extensive investigation. Further study, if it is to encompass the field adequately is dependent upon the observation and responsibility of the clinician. As the number of cases of this nature which are referred for study increases, so will increase the value of this laboratory aid to the physician. *Rocky Mountain Medical Journal, January 1965.*

Medical Progress



Harvey Kravitz, M.D./progress editor

LIVER FUNCTIONS IN CLINICAL MEDICINE

Frederick Steigmann, M.D./chicago

CONCLUSION

Lipid Metabolism

Cholesterol. The liver is an important source of serum cholesterol. The normal level is 150 to 250 milligrams percent. In hepatocellular disease the level remains constant or falls slightly, the latter especially in severe forms of hepatitis.

In intrahepatic cholestasis the cholesterol concentration may be very high, as in xanthomatous biliary cirrhosis, cholangiolitic hepatitis, and early viral hepatitis. If liver cell damage progresses the cholesterol tends to fall further. Hence, low levels of cholesterol usually indicate advanced liver disease, since they are seen only occasionally in malnutrition.

In severe hepatocellular degeneration such as fulminating viral hepatitis, the cholesterol levels may be very low. In acute hepatitis the cholesterol level is elevated only if protracted cholestasis is present. In most forms of cirrhosis total serum cholesterol level is low except in biliary cirrhosis where it may rise to over a thousand milligrams percent.

In obstructive jaundice, and hepatitis with intrahepatic cholestasis it rises markedly. However, if the obstruction is mild the rise may be only minimal.

The mechanisms for the serum cholesterol fluctuation are poorly understood. The fall of cholesterol in liver cell damage is thought to be due to decreased synthesis of cholesterol by the liver. The rise in obstructive jaundice could be due to an alteration in the physical properties of the serum proteins since elevation of bile acids increases the cholesterol binding ability of the serum proteins. The latter might lead to interference with normal removal of cholesterol from the blood.

High levels of cholesterol are seen in

Hektoen Institute for Medical Research and the Department of Gastroenterology, Cook County Hospital; Department of Medicine, University of Illinois College of Medicine.

biliary obstruction; relief of the obstruction reduces the total serum cholesterol level.

The cholesterol occurs in both the free and esterified form. Normally the free cholesterol is 25 to 35 percent of the total cholesterol while the esters are 65 to 75 percent, regardless of the total value. The cholesterol ester ratio has a tendency to drop in liver cell damage. Values below 20 percent are mostly the result of liver damage.

In hypercholesterolemia, a high ester ratio is found, but in hypercholesterolemia with liver damage the ratio drops. Thus in subjects with high levels of cholesterol mild liver damage may drop the percentage of cholesterol esters; however, in those with low cholesterol levels more severe liver damage is necessary to lower the cholesterol esters. The cholesterol esters drop precipitously in fulminating and fatal forms of hepatitis and a very low cholesterol ester is a poor prognostic sign. In cirrhosis with jaundice the cholesterol ester ratio is low. In tumor metastasis the ratio is frequently depressed.

In general the serum cholesterol is not a sensitive indicator of liver cell damage.

Enzyme Activities

The Alkaline Phosphatase. The determination of the alkaline phosphatase activity is a test which is widely used in jaundice and in liver disease. Its activity is increased more in cholestasis than in hepatocellular degeneration. The mechanisms for this are not fully understood. However, because the enzyme occurs in bones, intestinal mucosa and the liver and is excreted in the bile it is believed that the increase in serum alkaline phosphatase may be caused by: (1) a piling up or regurgitation of phosphatase of extrahepatic origin particularly in cholestasis, (2) an increased formation by the hepatic cells in the presence of hepatic cell damage or cholestasis, and (3) an increased formation by the proliferated ductules. The latter may account for the high levels seen in cholestasis and other conditions with ductular proliferation. In the jaundiced patient, therefore, a slight elevation may indicate hepatocellular damage whereas a marked one implies extrahepatic or intrahepatic cholestasis.

The above, however, does not explain the much higher levels in obstructive than hepatic jaundice or the high levels in nonicteric patients with biliary fistulae, cholangitis or liver malignancy. One theory that the high phosphatase is due to the presence of a catalytic agent that enhances enzyme activity has never been proven. The other theory that a high phosphatase in obstructive jaundice is due to increased production of the enzyme, because of osteomalacia secondary to steatorrhea and vitamin D loss, does not explain its rise in non-icteric liver disease or its prompt drop following relief of an obstruction in the common duct. Hence, as evidenced from experimental and clinical data overproduction of phosphatase by the liver in response to hepatocellular injury or increased intraductular pressure, or inflammatory diseases of the ducts, or space occupying lesions which compress the liver cells and ductules or a combination of the above is probably the most likely cause for an increased alkaline phosphatase.

Normally the alkaline phosphatase activity is usually 1.5 to 4 units by the Bodansky and 3 to 13 units by the King-Armstrong method. In children the values are higher, ranging from 4 to 8 Bodansky units. In conditions where there is bone activity such as Paget's disease, rickets, and primary or secondary bone tumors the values are also high. Starvation lowers the alkaline phosphatase, fat ingestion increases it. It is mildly elevated in passive congestion of the liver. In hepatocellular damage the alkaline phosphatase activity is usually moderately elevated between 4 and 12 Bodansky units or up to 30 King-Armstrong units. The elevation does not correlate well with the degree of hepatic cell damage, or with the degree of jaundice, the latter probably because phosphatase is less readily excreted in the bile. The alkaline phosphatase activity is moderately elevated in viral hepatitis; persistent elevation indicates chronicity. In cirrhosis variable results are found; in the forms without jaundice the elevation is slight and only exceptionally high. In cirrhosis with jaundice the values are usually higher; with

severe jaundice the values may rise very high. In extrahepatic cholestasis the values are above 12 Bodansky units. Increased alkaline phosphatase is a reliable sign of cholestasis.

In incomplete, infected or subsiding hepatic obstruction the elevation of the alkaline phosphatase activity is often out of proportion to the degree of jaundice. In cholangiolitis the activity may be high even in the absence of jaundice. In prolonged obstruction the levels become very high and may reach 50 Bodansky units. The activity is moderately elevated in intrahepatic cholestasis but levels approaching 50 Bodansky units are rare. There may be a progressive increase in the alkaline phosphatase activity during the course of diseases associated with jaundice and intrahepatic cholestasis.

In granulomatous lesions of the liver the alkaline phosphatase is slightly elevated, particularly in tuberculosis and sarcoidosis. If cholestasis is associated with the granuloma the alkaline phosphatase activity increases. In severe hepatic failure the alkaline phosphatase may be low. However, a patient with prolonged extrahepatic biliary obstruction usually dies with a high alkaline phosphatase activity, although in some instances, severe hepatic failure may occur terminally. In primary tumors of the liver the serum alkaline activity is often increased and becomes very high when one of the large intrahepatic bile ducts is obstructed. A moderate elevation occurs in carcinomatous metastases to the liver even in the absence of jaundice. Increased phosphatase activity is found in about 90 percent of patients with advanced hepatic metastases; in many of them before there is enlargement of the liver. If bone metastases are also present the phosphatase activity may reach an even higher level (over 30 units). In patients with hepatic abscess an elevation of the alkaline phosphatase activity occurs in the absence of jaundice, merely as an indication of a space occupying lesion. A high alkaline phosphatase is usually found in cholestasis whether extrahepatic or intrahepatic (as in hepatitis, cirrhosis, cholangiolitis, xanthomatous biliary cirrhosis), in primary and metastatic carcinoma of the liver, in biliary fistula and hepatic tuberculosis. Fatty liver and acute hepatitis may have a normal serum alkaline phosphatase. The interpretation of the results of the alkaline phosphatase determination requires, therefore, a careful evaluation of all facts on hand.

Transaminases

In addition to the alkaline phosphatase the enzymes which have gained a sufficient acceptance for the diagnosis and differentation of patients with jaundice are the SGOT, and the SGPT. We have also been determining the ICD, OCT, LDH and Guanase. The results of these determinations have been in most instances of aid in the differential diagnosis of jaundice.

The Serum Glutamic Oxaloacetic Transaminase (SGOT). This enzyme which catalyzes the reaction of glutamic + oxaloacetic acid to ketoglutaric + aspartic acid is found in most tissues of the body; the greatest concentration being found in the heart and the liver.

During the acute phase of viral hepatitis of both the infectious and serum homologous type, the level of this enzyme is markedly elevated. The level usually decreases more or less rapidly to normal within four to eight weeks after the onset of the disease. A persistent elevation seems to denote continuing activity, although infection outside the liver may also be responsible for maintaining a high enzyme level. A secondary rise signifies a possible relapse. Values over 500 units almost always imply hepatitis.

Determining the serum transaminase levels and the bromsulphalein retention seems to be an effective screening procedure for anicteric hepatitis. The SGOT determinations also appear useful in the follow-up study of acute and chronic hepatitis, and for detection of relapse or recurrence. In fulminating hepatitis the serum transaminase levels may fall abruptly during the period of acute clinical manifestations with deepening jaundice. Clinically the serum transaminase activity and the serum bilirubin level do not always correlate.

Only moderate elevations in serum trans-

aminase levels were found in cirrhotic patients, most of the values found being less than 200 units. A rise in the SGOT level to over 300 units in a cirrhotic patient would, therefore, suggest a superimposed hepatitis. The stage of the cirrhosis or its activity as measured by the presence of jaundice ascites and even coma, usually does not correlate with the level of the SGOT. In patients with biliary cirrhosis and postnecrotic cirrhosis the increase in SGOT activity was greater than that noted in portal cirrhosis.

Patients with obstructive extrahepatic jaundice whether due to stones or malignancy manifested only a slight rise in the SGOT. However, when metastases to the liver were also present in these patients the SGOT level was noticeably higher. Malignant tumors of the liver were often associated with a high SGOT level.

The SGOT activity was usually within normal limits in patients with gastritis, peptic ulcer and gastric cancer without metastasis. Hence, in patients with cancer of the gastrointestinal tract a definite increase in serum transaminase activity may point to hepatic metastasis if other complications can be excluded.

SGOT in Alcoholics

In alcoholics with fatty liver the SGOT level was elevated during the acute delirium tremens state, even when there was no other evidence of hepatic disease. Increased SGOT levels were also found in the majority of patients with acute pancreatitis and alcoholism.

Serum Glutamic Pyruvic Transaminase (SGPT). This enzyme which catalyzes the reaction of glutamic + pyruvic acid to ketoglyturic acid + alanine is distributed mostly in the liver so that a high SGPT activity is a more specific sign of liver damage than a high SGOT activity.

In acute viral hepatitis the SGPT level is markedly elevated; it is higher than the SGOT. In cirrhosis, obstructive jaundice, metastatic carcinoma, and cardiac liver congestion the elevation is moderate.

The SGPT level appears specifically to indicate hepatic disease or involvement of the liver in other types of diseases.

Serum Ornithil Carbamyl Transferase (SOCT). This enzyme catalyzes the reversible conversion of ornithine to citrullin and is ultimately involved in urea synthesis. It is found in particularly large amounts in the liver.

Increased SOCT levels were found among patients with definite liver and biliary tract conditions, but occasionally also among patients with myocardial disease.

In acute hepatitis, SOCT activity increased remarkably in the early stages and correlated with the changes in SGOT, SGPT and serum bilirubin. Only slight changes in the SOCT activity were seen in patients with chronic hepatitis, cirrhosis and bile duct disease. Thus a marked increase in SOCT activity pointed to the existence of hepatic cell damage.

SICD Activity

Serum Isocitric Dehydrogenase (SICD). This enzyme catalyzes the reversible dehydrogenation and decarboxylation of isocitrate.

The normal levels of isocitric dehydrogenase range from 30 to 192 units. Men seem to have a slightly higher SICD level than women. Above 300 units, the isocitric dehydrogenase is considered abnormal.

The SICD activity was found significantly increased in acute hepatitis—occasionally before the appearance of jaundice—and to a lesser extent in other liver diseases associated with inflammatory, malignant, or necrotic changes. Only slightly elevated values, however, were found in patients with cirrhosis and obstructive lesions. A high SICD activity may be found in placental infarction and in carcinoma of the prostate.

In extrahepatic obstruction—pancreatitis, common bile duct obstruction, cholangitis, carcinoma of the head of the pancreas—the SICD may be slightly elevated. In hepatic necrosis, however, the SICD level may fall markedly. In intrahepatic obstruction and primary biliary cirrhosis the SICD level may be high. The SICD values in primary or metastatic carcinoma of the liver were variable. In some cases of extrahepatic obstruction the SICD levels were increased; the reason for this is at present being investigated.

Serum Lactic Dehydrogenase (SLDH). The enzyme LDH catalyzes the conversion of pyruvic acid to lactic acid in the presence of the coenzyme dihydrodiphosphopyridine nucleotide. The LDH is represented by 5 isoenzymes, three of which are especially valuable; the LDH #1 found mostly in the liver and the LDH #4 and #5 found mostly in the heart muscle. The first is inactivated on heating to 65 degrees centigrade while the latter is not affected.

The LDH is an insensitive test for hepatic disease. It is only slightly elevated in patients with hepatitis (viral or toxic), in cirrhosis or in obstructive jaundice due to biliary tract disease. It may be markedly elevated in patients with metastatic carcinoma of the liver or carcinoma of other areas. It is also elevated in megaloblastic anemia, leukemia and myocardial and pulmonary infarction and in heart disease. It is moderately elevated in various types of hemolytic diseases.

Serum Guanase. This test depends on determining the guanase in the serum by measuring the amount of guanine converted to xanthine by a fixed quantity of serum under specific conditions.

The guanase activity is high in hepatic cell damage, values over 100 units having been found. In neoplasms of the liver or biliary tract the guanase activity was slightly elevated. In cirrhosis and diseases of the biliary tract little guanase activity was found. The guanase activity appears early in hepatitis and drops gradually, occasionally abruptly, during convalescence. In patients going into the chronic stage it seems to remain at a high level.

Liver Biopsy

One of the procedures helpful in the differential diagnosis of jaundice is the performance of a liver biopsy. The latter is done mostly blindly either laterally through the chest wall or through an anterior right subcostal approach. It can also be done under vision during peritoneoscopy.

A biopsy taken during an operation from the liver edge is of limited value because too much fibrosis appears in the specimen. A biopsy taken through the peritoneoscope with forceps has similar disadvantages as the surgical biopsy taken during operation. However, if the biopsy is taken during peritoneoscopy with one of the presently used needles one can point the needle to the exact place from where one wishes to take the biopsy. This procedure is, therefore, preferable to a blind punch biopsy. Through the peritoneoscope, moreover, one can watch carefully for any bleeding and deal with it accordingly.

The indications for liver biopsy are: Differential diagnosis of jaundice, when there is a disagreement between laboratory and clinical features; persistent low grade jaundice; persistent symptoms after hepatitis; cholestasis of several weeks duration; to differentiate between intrahepatic and extrahepatic forms; hepatomegaly of unknown origin; nodular liver; diagnosis of granulomatous disease of the liver; check on the results of therapy; diagnosis of suspected hepatic involvement, e.g. as in fever of unknown origin.

Contraindications for Liver Biopsy

The absolute contraindications for liver biopsy are hemorrhagic diathesis, like hypoprothrombinemia, and thrombocytopenia, cholemia, prolonged obstructive jaundice, cholangitis, liver abscess, infection or pathology in the right pleural cavity or the right lower lobe of the lung. Relative contraindications may be considered: congestive heart failure, ascites, hypertension, anemia, and lack of cooperation on the part of the patient.

The results of liver biopsy concerning diagnosis vary with the number of liver biopsies done and vary with the indication for it. When liver biopsy is done on a large scale, the established clinical diagnoses are often confirmed and unsuspected lesions detected. Nevertheless, in a large series, the biopsies are of no help in almost 30 percent of the cases. The usefulness of the procedure depends on the adequacy of the specimen obtained. In 10 percent of biopsies there may be failure to obtain an adequate specimen.

For focal lesions such as tumors and granulomas most specimens may suffice, if the characteristic lesion is found with the specimen. On the other hand, large specimens are desired in order to reduce the incidence of negative biopsies. Nodules

seen on gross inspection and not on the histologic section call for an examination of serial sections. One must have at least three lobules with one or two portal tracts for a diagnosis of hepatitis.

The above discussion of liver function tests should give the practicing doctor a brief review of the basis of these tests and what can be expected of them as an aid in the diagnosis of a given case with liver disease with or without jaundice. The table presented in Part I showed a very broad summary of the differential factors between the medical and surgical types of jaundice in typical instances. Unfortunately, however, most cases are not quite typical. The clinician therefore must evaluate each patient not solely according to the data presented on the table but only with the latter data as a background to the patient's presenting symptoms and findings.

TREATMENT OF THYROID CARCINOMA

During the last few years, it has become increasingly evident that carcinomatous changes in the thyroid may be multicentric and that there may be intrathyroid seeding from one lobe to another and even lymph node metastases on the other side of the neck. With the usual microscopic procedures, multicentricity of the lesion has been found to occur in some 20 to 30% of cases of papillary and follicular carcinoma; extension of the process to the other lobe was seen in a similar proportion of cases (Black and associates; Lindsay). In a more recent study, extension to the other lobe was found in about 35% of cases when routine microscopic methods were used. The figure rose, however, to over 80% when a subserial study was carried out of the thyroid tissue. Similar findings were obtained when the thyroid tissue was studied at a secondary operation; residual carcinoma was found in 36% with the usual methods and in 76% with subserial study (Clark and associates). Hirabayashi and Lindsay observed local recurrence of cancer in 13% after hemithyroidectomy against 2% after total eradication of the thyroid. Furthermore, the outlook for the patient is much graver when there are distant metastases present as evidenced by published survival rates. *International Surgery*, January, 1966.

SARCOIDOSIS

AND RHEUMATOID ARTHRITIS

William R. Thompson, M.D., and George W. Ferenzi, M.D., F.A.C.P.**/chicago*

THE ENIGMA OF SARCOIDOSIS has not been solved. A disease of exceedingly varied manifestations or a syndrome resulting from an unknown response to an unknown agent or agents? It is known that many substances other than tubercle bacilli can stimulate the formation of peculiar epithelioid cellular granulomata. It is known that certain diseases may occur in association with sarcoidosis. Gout and psoriasis are recently described examples.[1] It is thought that damaged immunologic responses may be significant in the pathogenesis of the disease.

Indispensable to the diagnosis of sarcoidosis is the demonstration by biopsy of epithelioid granulomata with little or no necrosis. There must be a failure to demonstrate organisms or substances which could have caused the reaction. The clinical manifestations must at least be suggestive. A positive Kveim test is a nice decisive boon to the disbeliever.

The patient to be described illustrates the occurrence of sarcoidosis in the presence of another puzzling entity, chronic rheumatoid disease.

Report of Case

A thirty year old colored woman was first seen in the Mercy Clinics during December 1956. She complained of multiple joint pains which have progressed over the previous seven years to produce ankylosing deformities of both hands. She was diagnosed as having rheumatoid arthritis and followed intermittently with conservative therapy until September 1961. At that time she had an arthroplasty of the proximal interphalangeal joints of the right index and middle fingers using a Flatt prosthesis. Following the arthroplasty, a complete tooth extraction was done which necessitated a tracheostomy because of difficulty in intubation due to arthritic temporamandibular involvement. She was not seen again until January 1964 when she complained of increasing fatigue over the previous six months. She felt well in the morning but became worse as the day progressed. A fever ranging up to 102°F. had been present during this time. A gradually enlarging mass in the left upper abdominal quadrant had been noted for the previous two years. A total of thirty pounds in weight had been lost. She stated that she bruised easily but did not bleed excessively. The only medications were aspirin and an oral iron preparation.

The patient was born in New Orleans. At the age of 12 she contracted rheumatic fever which was manifested by joint involvement. There was no known recurrence. She moved to Chicago in 1949.

*Director of Medical Education at Mercy Hospital and Clinical Instructor at Stritch School of Medicine. **Attending in Hematology at Mercy Hospital and Assistant Clinical Professor at Stritch School of Medicine.

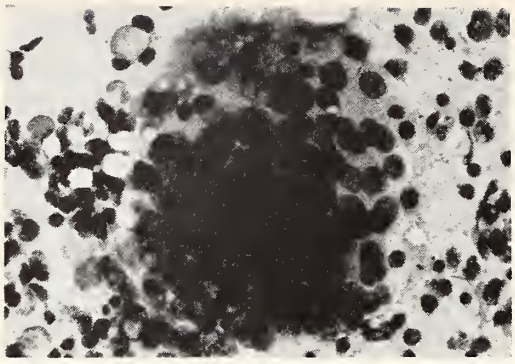


Figure 1: Marrow particle smear. Wright giemsa stain. Cluster of epithelioid cells in a synctial mass. × 400

Physical examination showed a tall, trim, colored woman. Small shotty lymph nodes were found in the posterior triangles of the neck and in the supraclavicular areas. Large, movable lymph nodes were palpated in the axillae. The lungs were clear. A grade 2/6 systolic ejection murmur was heard at the second left intercostal space. The spleen was enlarged almost to the iliac crest. It was firm and nontender and measured ten centimeters below the left costal margin. The liver was not palpated. There were deformities of the small joints of the hands and the feet with considerable limitation of motion. There was limitation of abduction of the hip joints and limitation of flexion of the knee joints.

The temperature was 100.8°F.; pulse 100 per minute; and respirations 26 per minute. The blood pressure was 102/70 mm. mercury.

The urine gave a trace to one plus test for protein. The hematocrit was 22% with a hemoglobin of 7 grams per 100 ml. of blood. The erythrocytes numbered three million per cmm. The leukocyte count was 2200 with 33% segmented neutrophiles, 19% band forms, 6% eosinophiles, 8% monocytes, and 31% lymphocytes. Repeated counts showed the total leukocytes to number up to 7900 per cmm. with as high as 86% neutrophiles. The thrombocytes numbered 258,000 per cmm. The sedimentation rate was 15 mm. per hour. The reticulocyte count was 0.8%. The two hour postprandial blood glucose was 129 mg., urea nitrogen 41 mg., uric acid 3.8 mg., calcium 8.2 mg., and phosphorus 4 mg. per 100 ml. of blood. The serum iron was 20 micrograms per 100 ml. of blood with an iron binding capacity of 370 micrograms. The serum bilirubin was 0.6 mg. total with 0.25 mg. direct reacting bilirubin per 100 ml. of blood. A serum protein electrophoresis showed the albumin to be 3.08 grams, alpha 1 globulin 0.24 grams, alpha 2 globulin 0.42 grams, beta globulin 0.93 grams, and gamma globulin 2.14 grams per 100 ml. of blood. The serum glutamic oxalacetic transaminase was 32.5 units, the serum glutamic pyruvic transaminase 7 units, the lactic dehydrogenase 550 units, and the alkaline phosphatase 9 Bodansky units. The prothrombin time was 12.3 seconds with a control of 13.5 seconds. Three lupus erythematosis preparations were negative. A latex fixation for rheumatoid factors was 1:160. An indirect and direct Coombs test was negative. The VDRL was nonreactive. Red blood cell survival time (chromium 51) was 24 days which was 40% of the calculated value. This suggested selective sequestration of erythrocytes in the spleen.

A roentgenogram of the chest showed bilateral vascular infiltrates in the lung fields. Roentgenograms of the hands and feet were compatible with advanced rheumatoid arthritis with osteoporosis. The hips showed narrowing of the joint spaces with sclerosis around the joint margins. Roentgenograms of the skull and spine were normal.

A tuberculin skin test with intermediate strength purified protein derivative was negative. Bone marrow aspiration revealed clusters of reticulum-type cells with abundant opaque cytoplasm. The cytoplasm varied from a hyaline blue to a finely granular ground glass appearance with and without vacuolar changes. The nuclear chromatin was reticular with a round. oval, or elliptical nucleus and contained one or two small, blue staining nucleoli. Multinuclear large cells were readily evident. The abundant cytoplasm and nuclear characteristics gave the cytological appearance of an epithelioid cell (Figures 1 and 2). This was considered consistent with sarcoidosis as was a biopsy of the liver and a right axillary node. A biopsy of the synovium of the right knee showed a chronic synovitis consistent with rheumatoid arthritis (Figure 3).

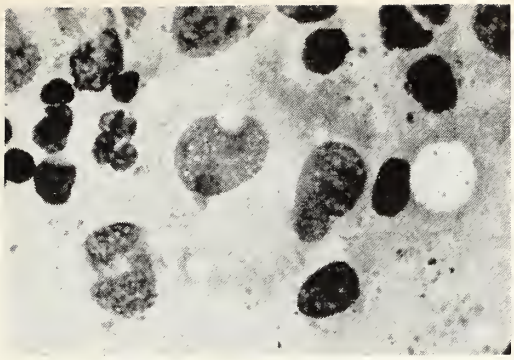


Figure 2: Marrow particle smear. Wright giemsa stain. Multinuclear giant cell. × 1000

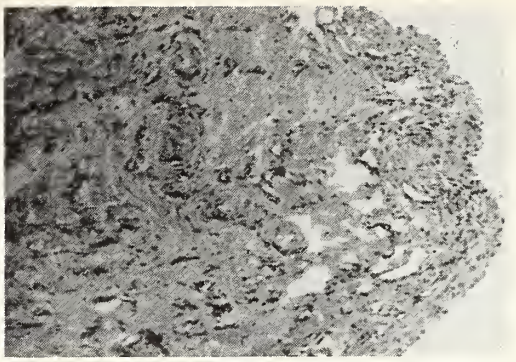


Figure 3: Synovium section. Chronic granulomatous inflammation beneath the synovial membrane. × 100

The patient was started on 40 mg. of prednisone* per day. After several weeks this was reduced to a maintenance dose of 10 mg. per day. There has been some reduction in the size of the spleen and alleviation of the fever. Needless to say there have been no joint pains.

Comment

The exact incidence of bone involvement in sarcoidosis is not known and there is an estimate of approximately 20%. Osteolytic lesions of the skull and vertebrae may simulate multiple myeloma, metastatic disease, and infiltrative diseases such as Hand-Christian-Schiller and eosinophilic granuloma.[2,3] The incidence of arthropathy of some type in sarcoidosis is probably higher than the twenty-five per cent so often mentioned in the literature. The elucidation and classification of the type of joint involvement is often difficult. Recently, a review of sarcoid arthritis has been published.[4] Many authors have described rheumatoid-like deformities and are often not remiss in pleading difficulty in differentiating between sarcoid joint disease and rheumatoid joint disease. Can sarcoidosis coexist with rheumatoid disease?

Much effort is expended to demonstrate the presence of rheumatoid factors in the serum of patients with joint disease clinically suggestive of rheumatoid arthritis. A high titre of rheumatoid factors, a consistent clinical picture, and the demonstration by biopsy of a chronic synovitis should satisfy most physicians that rheumatoid arthritis is indeed the proper diagnosis. If there is added to this triad the demonstration of sarcoid granulomas, acceptance of the diagnosis of sarcoidosis and rheumatoid arthritis coexisting in one patient should be an inevitable conclusion. Our patient satisfied all of these criteria. The presence of rheumatoid factors in patients with sarcoidosis has been reported.[5,6] These patients did not have clinical rheumatoid arthritis.

Synovial biopsy in patients with clinically evident rheumatoid arthritis shows a nonspecific inflammatory reaction.[7,8] Synovial biopsies in sarcoid joint disease often show a granulomatous inflammation consistent with the diagnosis of sarcoidosis.[9] Occasionally, a biopsy will show only evidence of a diffuse, nonspecific synovitis. The greatest value of a biopsy of the synovium may be the elimination of more specific possibilities. In the patient we have presented, the biopsy was more consistent with the diagnosis of rheumatoid arthritis than with sarcoidosis.

The aspiration of epithelioid clusters was completely fortuitous at the site aspirated, the right posterior iliac crest. Subsequent surgical curettement of the same site revealed the histological picture consistent with sarcoid granuloma. (Figure 4) Bone marrow findings in sarcoidosis are generally nonspecific disclosing a reactive myeloid hyperplasia with eosinophilia, increase in reticulum cells, and plasmacytosis.[10] The marrow of this patient showed these same changes as well as the epithelioid clusters. Such reactive changes may also be seen in any granulomatous, neoplastic, toxic, con-

*West-ward, Inc.

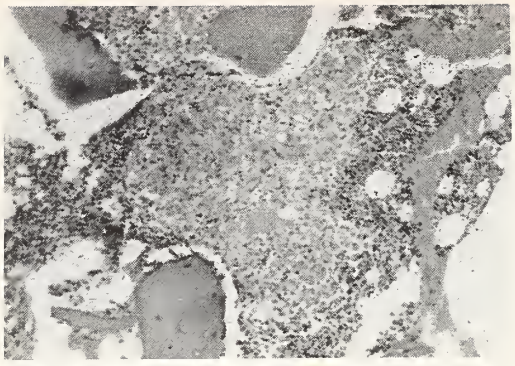


Figure 4: Curettement of iliac crest marrow. Sarcoid granuloma.

nective tissue disease or chronic infective state.

The triad of arthropathy, splenomegaly, and neutropenia (known as Felty's syndrome) is probably a variant of rheumatoid disease.[11,12] It is characterized by reticuloendothelial system stimulation manifested by secondary hypersplenism and neutropenia. A markedly enlarged spleen in the patient with joint manifestations should alert one to the possibility of this syndrome. In the patient we have presented, it was eliminated by virtue of the lack of documented persistent neutropenia. There was also the lack of characteristic bone marrow findings, namely, marked myeloid hyperplasia with a full myeloid spectrum and normal maturation, and a moderate erythroid hyperplasia. The anemia in this patient was due to iron deficiency substantiated by the low serum iron, increased plasma iron unsaturation and absence of stainable marrow iron granules.

Summary

A patient with long existent chronic rheumatoid disease has been presented. This patient subsequently developed clinical and histological manifestations of sarcoidosis.

Drs. George W. Changus and Earl J. Mason of the Department of Pathology interpreted the histologic sections.

References

1. Bunim, J. J. et al: The Syndrome of Sarcoidosis, psoriasis, and Gout. Ann. Int. Med. 57:1018-1040, Dec. 1962.
2. Goobar, J. E. et al: Vertebral Sarcoidosis. J.A.M.A. 178:1162-1163, Dec. 23, 1961.
3. Teirstein, A. S. et al: Sarcoidosis of the Skull. New Engl. Jr. Med. 265:65-68, July 13, 1961.
4. Kaplan, Herbert: Sarcoid Arthritis. Arch. Int. Med. 112:924-935, Dec., 1963.
5. Kunkel, H. G. et al: Positive Serologic Reactions for Rheumatoid Arthritis in Sarcoidosis. Arth. & Rheum. 1:289-296, Aug. 1958.
6. Jacobson, et al: Sheep Cell Agglutination. Am. Jr. Med. 20:490-499, April 1956.
7. Kodama, T.: Histological Findings from the Synovial Membrane and Surgical Treatment of Affected Joints in Rheumatoid Arthritis. Acta Rheum. Scand. 6:48, 1960.
8. Rodnan, G. P. et al: Experience with Punch Biopsy of Synovium in the Study of Joint Disease. Ann. Int. Med. 53:319-331, Aug. 1960.
9. Israel, H. L. and Sones, M.: Selection of Biopsy Procedures for Sarcoidosis Diagnosis, Arch. Int. Med. 113:255-260, Feb. 1964.
10. Leitner, S. J.: Bone Marrow Biopsy. English translation by Britton, C. J. C. and Neumark, E. J. & A. Churchill, London 1949.
11. Denko, G. W. and Zumpft, G. W.: Chronic Arthritis with Splenomegaly and Leukopenia. Arth. & Rheum. 5:478-490, Oct. 1962.
12. Mason, D. T. and Morris, J. J.: The Variable Features of Felty's Syndrome. Am. Jr. Med. 36:463-468, March 1964.

NON-DIABETIC KETOSIS IN DIABETES DURING LATE PREGNANCY

Hugo R. Rony, M.D., F.A.C.P./chicago

Pregnancy may be considered a diabetogenic event; a woman's diabetes frequently grows worse when she becomes pregnant, and the likelihood of ketoacidosis is greater, especially during the last half of pregnancy.[1] This ketosis is usually accompanied by marked hyperglycemia, glycosuria, and carbohydrate deprivation.

The subject of the present report is a young, obese woman who has had for years a mild, non-insulin requiring, nonketotic diabetes but developed marked ketosis on moderately low caloric diets with moderately low carbohydrate content during the third trimesters of each of three consecutive pregnancies. There was no glycosuria, and the fasting blood sugars were normal during these periods. The ketosis diminished and soon disappeared on high carbohydrate diets and, after the childbirths, did not reappear on low caloric, low carbohydrate diets.

Case Report

E. C., a 25-year-old obese woman, was admitted to the hospital on October 30, 1960 because of acetonuria. She was in the eighth month of pregnancy and was known to have had diabetes for six years. She came from a diabetic family, her mother, a sister and an uncle having diabetes. She lived on unrestricted diet, used no insulin or antidiabetic drugs, and had but occasional glycosuria until three months prior to admission. At that time, the urine gave a 4 plus reaction for glucose, negative reaction for acetone, and the fasting blood sugar was 160 mg. per 100 ml. Her weight was 264 lbs. A 1500 calorie diet containing 100 gm. protein, 150 gm. carbohydrate and 50 gm. fat with 0.5 gm. tolbutamide was prescribed upon which she lost 20 lbs. in three months, the glycosuria disappeared but the urine gave a strong reaction for acetone.

On admission, she had no complaints. Physical examination was essentially negative except for obesity and pregnancy; her weight was 244 lbs. The blood pressure was 110/70. A complete blood count was normal. Blood cholesterol was 216 mg., blood urea nitrogen 9 mg. per 100 ml. The urine was normal except for a strong reaction of acetone. Figure 1 shows the data of her daily diet. blood sugar and urinary sugar and acetone. It is seen that on the first two days, on moderately low caloric, low carbohydrate diet there was marked acetonuria without glycosuria, and the fasting blood sugar was normal. As the daily carbohydrate intake was increased during the next three days to 200 gm., the acetonuria began to diminish and some glycosuria appeared, the fasting blood sugar remaining normal. The next two days, the daily carbohydrate intake was increased to 250 gm., with the result that the acetonuria completely disappeared, the glycosuria increased somewhat while the fasting blood sugar still remained within normal limits. She was discharged from the hospital at the end of the week with instructions to continue with the high carbohydrate diet. She had slight glycosuria without acetonuria until she was admitted a month later to another hospital where she gave birth to a healthy 12 lb. boy. After the childbirth, she was advised to follow a low caloric, low carbohydrate diet which she tolerated without glycosuria or acetonuria.

Clinical Associate Professor of Medicine, Chicago Medical School; Senior Attending Physician in Endocrinology and Metabolism, Mount Sinai Hospital, Chicago.

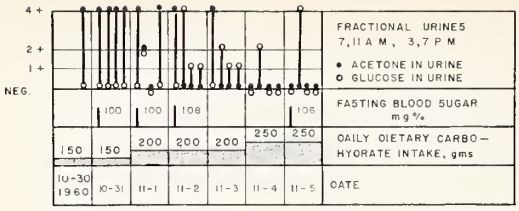


FIG 1 FIRST PREGNANCY

(see text)

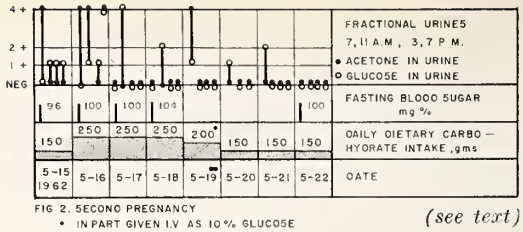


FIG 2. SECOND PREGNANCY
• IN PART GIVEN I.V. AS 10% GLUCOSE
⇔ CHILDBIRTH

(see text)

Soon, however, against advice, she resumed unrestricted eating.

There was a second pregnancy, in 1962, and a third, in 1964. The changes in her diabetes during these two pregnancies were similar to those observed during her first pregnancy. She lived on unrestricted diet between the pregnancies and during the first trimesters of the pregnancies, reporting occasional slight glycosuria. During the second trimesters of the pregnancies, glycosuria became marked, the fasting blood sugars ranging between 150 and 180 mg. per 100 ml.; there was no acetonuria. Her weight was 260 to 265 lbs. As it was desirable to control her diabetes as well as her weight, she was again urged to follow moderately low caloric, low carbohydrate diets upon which the fasting blood sugar and glycosuria decreased but acetonuria appeared. She was hospitalized both times in the 36th week of pregnancy. The acetonuria again disappeared when the carbohydrate intake was increased to 250 to 300 gm. daily, the fasting blood sugars remaining within normal limits with minimal glycosuria (Figures 2 and 3). After a few days on the high carbohydrate diet, delivery was induced by i.v. Pitocin administration (attending obstetrician: Dr. Samuel J. Turner). The babies weighed 9 lbs., 10 oz., and 9 lbs., 11 oz., respectively. The last baby had severe postnatal hypoglycemia for three days but recovered on appropriate treatment without apparent damage. Immediately after the childbirths, the patient followed a low carbohydrate, low caloric diet without glycosuria or acetonuria.

Comments

Diabetic ketosis occurs when high level hyperglycemia with consecutive excessive glycosuria develops with rapid loss of glucose and depletion of carbohydrate reserves. Our patient had no fasting hyperglycemia and lost no significant amounts of glucose in the urine during the periods of ketosis; therefore, her ketosis must have had a different origin. Non-diabetic origins of human ketosis include prolonged starvation, excessive fat content of the diet with a minimum of carbohydrate (ketogenic diet), severe renal glycosuria, high fever, especially in childhood, and glycogen storage disease with the patient on low carbohydrate diet. Furthermore, ketosis occurs in certain lactating ruminants ("bovine ketosis")[2] and in guinea pigs, rats, goats, cows and ewes during late pregnancy if starved for several days ("fasting ketosis of pregnancy").[2] Finally, administration of human growth hormone to human individuals of either sex on normal diet may be followed by marked ketosis.[3] Of all these kinds of ketoses, the fasting pregnancy ketosis of animals deserves first consideration as possibly related to the non-diabetic ketosis of our pregnant diabetic patient. Reports on ketogenesis in normal pregnant women during prolonged fasting are not available but there is some evidence to show that in late human pregnancy, after an overnight fast, a state of "accelerated starvation" exists with augmented mobilization of fat from the fat depots, creating a ketogenic tendency.[4] Conceivably, such tendency could lead, on prolonged fasting, to manifest ketosis. However, our patient was not on prolonged fasting at any time during her ketotic periods; she never ate less than a daily 1500 calorie-150 gm. carbohydrate diet, and some acetonuria was present even when she consumed as much as 200 gm. carbohydrates daily. Accordingly, it is probably safe to say that "fasting pregnancy ketosis" was not in itself the sole or even a major factor in her ketosis.

Among the ketogenic factors possibly involved in pregnancy ketosis, the pituitary growth hormone may be of special interest. As mentioned above, injections of human growth hormone can produce ketosis in non-fasted individuals. Elevated levels of

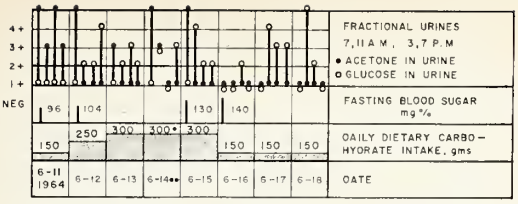


FIG. 3. THIRD PREGNANCY
*IN PART GIVEN I.V. AS 10% GLUCOSE
**CHILDBIRTH

(see text)

growth hormone were found in the blood of pregnant rats.[5] Using immuno-assay techniques, Ehrlich and Randle[6] found normal levels of growth hormone in the plasma of normal pregnant women, high levels in obese male and female diabetics, and high levels in the majority of obese or non-obese pregnant diabetics; the high levels approached those found in acromegaly. If confirmed, these data would suggest that excess growth hormone could indeed be the source of our patient's ketosis since she was obese as well as pregnant and diabetic. However, growth hormone administration to diabetics is invariably followed by increased hyperglycemia and glycosuria,[7] while the patient's ketosis was always accompanied by normoglycemia and aglycosuria. Accordingly, the role of the growth hormone in the ketosis of the patient remains problematic.

Is it possible that the patient has been in carbohydrate deprivation resulting in ketosis—in spite of ample carbohydrate intake—because of excessive utilization of glucose by the large fetus? The glycosuria of some diabetic mothers is known to improve during the last trimester of pregnancy,[1] presumably because of the insulin production of the fetus' pancreatic islets. It is known that glucose can pass the placental barrier since high rates of glucose-C^{14} transfer have been demonstrated when the plasma glucose concentration on either side of the placenta was kept low.[8] Accordingly, it is conceivable that low glucose concentration in the fetal blood leads to a transfer of considerable amounts of glucose from the diabetic mother's blood. This would explain the normoglycemia and aglycosuria of the patient during late pregnancy. It is not likely, however, that glucose deprivation produced this way in the mother would be massive enough to cause marked ketosis.

It appears then that neither of the three possible origins listed above—"accelerated" fasting, excess growth hormone production, excess utilization of glucose by the fetus—would by itself fully explain the "non-diabetic ketosis" of the patient. Presumably, a combination of any two or of all three may be required to produce the phenomenon. Late pregnancy seems to be essential for this ketosis since no ketosis was observed before and after the pregnancies, and during the early pregnancies. What role, if any, the extreme obesity of the patient played is not clear. Obesity, in itself, is not "ketogenic"; on the contrary, it is much more difficult to induce ketosis in obese than in non-obese persons.[9]

Non-diabetic ketosis without hyperglycemia and glycosuria in late pregnancy diabetes is probably rare, but forms in which ketosis is accompanied by relatively mild hyperglycemia and glycosuria may be more common.[10] It is of practical importance to recognize this syndrome since 1) it is relatively benign and constitutes no cause for alarm; 2) it can be promptly rectified by high carbohydrate diet; and 3) administration of insulin, which is essential in the treatment of the usual form of diabetic ketosis, is not indicated and may be harmful.

Summary

A young obese woman with mild, non-insulin-requiring diabetes developed on moderately low caloric, low carbohydrate diet marked acetonuria during the third trimesters of three consecutive pregnancies. Each time the ketosis was accompanied by normal fasting blood sugar, and there was no or but a trace of glycosuria. The acetonuria promptly disappeared on high carbohydrate diet; insulin was not needed. Following the childbirths, low carbohydrate diets were tolerated without acetonuria. The practical importance of recognizing this syndrome is emphasized and the possible causes are discussed.

References

1. Kyle, G. C.: Diabetes and Pregnancy, *Ann. Intern. Med. 59* (Suppl. 3) 18, 1963.
2. Stevenson, D. E., and Wilson, A. A.: *Metabolic Disorders of Domestic Animals,* Philadelphia: F. A. Davis Co., 1963.
3. Raben, M. S., and Hollenberg, G. H.: Growth Hormone and Mobilization of Fatty Acids, *Ciba Foundation Colloquia on Endocrinology* 13:89-105, 1960.

4. Bleicher, S. J., et al: Carbohydrate Metabolism in Pregnancy, *New Engl. J. Med.* 271: 866-872, 1964.
5. Cantopoulos, A., and Simpson, M. E.: Increase of Growth Hormone in the Plasma of Pregnant Rats, *Endocrinology* 61:765-773, 1957.
6. Ehrlich, R. M., and Randle, J. J.: Immuno-Assay of Hormones, *Ciba Foundation Colloquia on Endocrinology* 14:125-145, 1962.
7. Henneman, D. H., and Henneman, P. H.: Human Growth Hormone, *Diabetes* 9:272-277, 1960.
8. Alexander, P., et al.: Placental Transfer of Sugars in the Sheep, *J Physiol (London)* 129: 367-383, 1955.
9. Kerwick, A., et al.: Resistance to Ketosis in Obese Subjects, *Lancet* 2:1157-1159, 1959.
10. Hagbard, L.: *Pregnancy and Diabetes Mellitus*, Springfield: Charles C Thomas, 1961, p. 62.

EARLY DIAGNOSIS OF UPPER GASTRO-INTESTINAL BLEEDING

Early assessment of the cause of upper gastro-intestinal bleeding is desirable. The methods employed for this purpose have been evaluated in 89 patients. In addition to assessing the clinical features, these methods included radiological examination by the gastrografin technique, studies of nocturnal gastric secretion, and endoscopy by means of the gastroduodenal fibrescope. Collaboration between physician and surgeon from the outset is essential.

Each of these methods has its particular limitations, and the best way of obtaining an accurate and rapid diagnosis lies in the use of several approaches.

Radiological examination and endoscopy are complementary in their diagnostic usefulness. Acute erosions could be diagnosed conclusively only by endoscopy, while radiological examination was valuable only in the detection of ulceration; the duodenum was, however, visualized by the gastroduodenal fibrescope in half of the cases in which it was attempted.

The determination of nocturnal gastric secretory patterns gave an accurate diagnosis in 64% chronic and acute ulceration. Although this procedure was disturbing to patients, it has a place among these diagnostic procedures.

The volume of blood lost was also calculated by means of radioiodinated human serum albumin. The following features suggested a blood loss of more than 1 Litre: pallor of the skin, tachycardia of 100/min. or more, a systolic blood-pressure of under 100 mm. Hg, and a haemoglobin level of less than 11 g./100 ml. Patients with a blood urea of 40 mg./100 ml. or over were more likely to have had a severe bleeding than those with a blood urea under 40 mg./100 ml. The estimation of blood loss was also found useful in the appraisal of patients presenting with a doubtful haemorrhage.

In circumstances where elaborate diagnostic procedures are not possible the most practical approach to early diagnosis would seem to be: (1) history and clinical examination; (2) early radiology; and (3) endoscopy if a diagnosis has not been achieved by numbers 1 and 2. C. Mailer et al. *Brit. M. J.* (October 2) 1965.

PATIENTS REFUSING PSYCHIATRIC TREATMENT

David W. Swanson, M.D./geneva

THE PERSON REFUSING MEDICAL treatment in a democratic society is supposed to be able to do so until he threatens the well-being of himself or others. Up to that point the refusal need not be explained, though religious, financial and personal reasons may be given by the reluctant patient. The person who is told that his behavior is "sick" is most likely to refuse treatment. In fact, it has happened so regularly that laws forcing confinement of the mentally ill are the responsibility of each state.[1]

Many is the method that has been tried to promote acceptance by an individual that his behavior is sick. (e.g. let's all go, we all probably need help; why don't you have a check-up by the nerve doctor.) For family member, friend, and physician, frustration and disappointment usually result. Most of these same interested people will have to continue dealing with an untreated patient as commitment may not be indicated or enforced.

This paper is a descriptive survey of 50 patients who refused psychiatric treatment in a suburban private practice setting. All patients refusing treatment were included in the study. Males and females were equally represented. The average age was 29 (12-62) with younger age groups predominant.

The Referral

The reason for referral in 80% of cases was behavior not tolerated in home or community. While family members might phrase their concern in terms of getting "help" for the patient, it soon became apparent that they no longer wanted to put up with withdrawal, lack of ambition, peculiar habits, sexual deviation, argumentativeness, outbursts of anger and irresponsibility. Some were troubled by a patient's threat of suicide or refusal to work or go to school.

Only 1 out of 5 patients who eventually refused the help offered came with problems they considered their own. This minority came with complaints of depression, fearfulness, addiction, ulcerative colitis, and less specific physical complaints. Two depressed females included in their request for treatment assistance in obtaining an abortion. Since this was felt medically unwarranted they were in a sense refused. At any rate no remaining advantages of psychiatric treatment were wanted by these 2 patients.

The patient's personal physician was involved in the referral in 60% of cases. He would originate the referral much less often than he was a middle man initially approached by the family. In the other 40%, referral came directly from family, school, friend, court, employer or the person came on his own.

It was not at all uncommon for the

Clinical Assistant Professor, Psychiatry and Neurology, Stritch School of Medicine, Loyola University.

patients, particularly the adolescent, to apparently not know why they were in the office. The problem had not been explained to them, perhaps on the supposition that had this been done, the family could not have gotten the patient to the psychiatrist's office. Clarifying the problem in the psychiatrist's office didn't seem to help.

The Patient's Presenting Problem

One-half of the patients did not admit that they were uncomfortable. They did complain of the interference of others in their lives and the waste of time in seeing a psychiatrist. Their stated problems were the inflexible attitudes and expectations of family members and associates. The remaining one-half of the patients admitted to some degree of discomfort. They were open in discussing one or the other of apprehension, sadness, insomnia, inability to control their temper, palpitations, skin rash, colitis and troubling thoughts. However, these also felt they did not belong in a psychiatrist's office but allegedly would have accepted treatment from another kind of physician.

On mental status evaluation, behavior ranged from a refusal of examination to embarrassed, passive indecisiveness. Most patients displayed varying degrees of mistrust and hostility in the form of belligerence, suspiciousness, guardedness, and aloofness. The exceptions were a few individuals who talked freely and displayed cleverness and charm. They refused treatment in an agreeable, disarming manner.

Diagnostically, there was a preponderance of the personality disorders (52%) with sociopathic features predominating. Psychoneurotic reactions (30%) and psychotic reactions (18%) completed the list. In the categories of psychoneurotic and psychotic reactions there was wide representation of the common clinical syndromes. In 80% of patients there was adequate contact with reality and an awareness that they were making a decision concerning their health.

For the most part these patients were not victims of sudden bewildering symptoms. Two-thirds had experienced their behavioral difficulties for 1 to 15 years. Only 3 had tried to cope with their problems for less than a month.

Information from collateral sources provided indication of previously existing traits or characteristics of the patients. Stubbornness or rigidity was noted in over one-third, and when it came to decision regarding treatment, these traits were still playing a prominent role. Another one-third were long considered impulsive in their decisions and judgments. The remaining one-third tended to be regarded as passive, indecisive and indifferent.

In the realm of work and social performance there was again an approximate distribution into thirds. One-third had functioned well, a third only fair and a third showed markedly impaired functioning. Only 3 patients had had previous psychiatric treatment, so discouragement at previous treatment failures was not a frequent reason for refusal.

The Refusal of Treatment

After examination and recommendation that psychiatric treatment be instituted, the patient proceeded to give his negative decision, but with varying degrees of conviction. Consistent with a stated lack of "a problem" most patients bluntly expressed disbelief in the examiner's decision. Their conviction that an error had been made was solid and often expressed in an unfriendly way. This type of answer came immediately.

A more passive refusal was given by a minority who rather courteously expressed the feeling that they could handle their own problems, or would have to, because they lacked the money for treatment. Yet they refused offers of finding clinic or other appropriate help. A similar minority expressed shame at the thought they would need psychiatric treatment. It was not worth the embarrassment it would allegedly cause other family members. This was despite the presence of these same family members in the psychiatrist's office trying to promote treatment.

The refusal of treatment was in many cases complicated by attitudes within the patient's family. In nearly one-half of the cases there was one family member who actively opposed psychiatric treatment along with the reluctant patient. The following cases were typical:

Case 1: This 15 year old boy was accompanied to the interview by both parents.

Mother obviously had initiated referral but father spent most of his time criticizing mother. Father felt there was no need for treatment and consistently defended his son's delinquent behavior.

Case 2: This 32 year old, married woman was brought for evaluation by her husband who felt treatment was necessary. During the diagnostic interview the patient's parents telephoned, protesting that nothing was wrong with their daughter and offered criticism of the patient's husband. The parents insisted she was ill but that the cause was physical.

Case 3: This 13 year old girl was brought to interview by her mother who was uncertain about need for treatment and indicated she would not force her daughter to get help, that the family physician was completely responsible for the referral. Father was refusing to commit himself either way and did not come for the appointment.

Case 4: This 49 year old married woman had been taken from a psychiatric hospital by her husband against medical advice. He was insisting she "snap out of it" herself and she had come for evaluation secretly. Despite some desire to accept treatment she didn't know how she could present this to her husband so refused.

Another factor in refusal of treatment was the patient's insistence that a family member needed the treatment and in 20% of cases some family member actually did show diagnosable psychopathology as the patient insisted. In these cases it was difficult to determine who needed help worse—patient or family member.

Case 1: This 15 year old girl was accompanied to interview by her mother. This parent was trembling, weeping and apprehensive. She gave a history of an anxiety reaction that had been present for at least two years, and in her mind entirely due to the patient's behavior.

Case 2: A 38 year old man was accompanied to the interview by his wife. She demonstrated tremulousness, obsessive thinking and many compulsive traits. She had undergone psychiatric evaluation in the past but had terminated treatment, feeling it unnecessary. She had drunk excessively as had the patient. She became antagonistic at the suggestion she be involved in treatment.

Other family attitudes caused concern. A long history of indulgence and unbelievable tolerance by the family of the patient's unusual habits or behavior could be noted. It then was understandable that the patient was unable to see why medical treatment was necessary now and not years ago. Psychiatric referral was in a few cases used by the family or patient as a manipulation, and a sincere motive for treatment was only partially present. It was used to deal with threats of divorce, legal action or removal from a school situation.

Follow-up

Some information following an initial refusal of psychiatric treatment was available in 60% of cases. The majority were still successful in avoiding any therapeutic intervention. About 1 of 5 patients eventually received treatment, generally through hospitalization following family persuasion or legal action. A small number developed into adequately motivated patients. One patient with a "psychosomatic" disorder chose to undergo a surgical procedure despite his physician's recommendation that psychiatric treatment be attempted. Three patients ended up in jail with their behavior being punished by legal means. Ten percent of patients were functioning satisfactorily and seemed to have partially justified their own insistence of not needing treatment.

Comment

Considerable effort has been expended to have the stigma and hopelessness of mental illness abandoned.[2, 3] Also to avoid a "mind-body" or psychiatric-medical split.[4] Yet many people not needing psychiatric care continue to look upon its necessity in someone else as an inadequacy, and continue to suspect that permanent personal and social changes will take place in an acquaintance requiring treatment. A partial understanding of this phenomenon is found in those willing to accept psychiatric help; even they may view their need for help as an indication of weakness or imperfection. The need for psychiatric treatment may be both of these but so may be a contracted pelvis, coronary artery disease and otosclerosis. Is the potential psychiatric patient correct in suspecting a greater gravity in his weakened ability to adapt?

The possibility exists, and such a conclusion seems to consciously or unconsciously be a considerable factor in refusing treatment.

The tendency to refuse treatment is not confined to any diagnostic category. It is more closely associated with the quality of insight which in turn requires enough confidence in one's environment to accept another's interpretation of one's behavior; and one's own belief that behavioral change is possible and advantageous. These qualities transcend the psychotic versus non-psychotic division. Even the more integrated patient may lack the sensitivity and sincerity necessary for an acceptance of treatment.

In this study adolescents resisted treatment more than any other age group and openly feared they were going to be discovered by a peer. Without total support by parents and other family their chances of accepting treatment are not good.

The construction of the referral is of importance because it is a controllable factor that may influence the patient's acceptance. The referring source can exert its most positive influence by getting family members to agree on the need for psychiatric evaluation. This done, neither the referring source or family should conceal their intentions from the patient. The reasons for suggesting psychiatric help should be stated clearly. The presumption, especially by referral sources outside the medical profession, that the psychiatrist can change a patient's negative attitude concerning treatment by some persuasive technique is as common as the unrealistic expectations of treatment.

Some patients seem to realize their behavior is atypical but this need not lead to acceptance of treatment. They often are gaining satisfaction and benefit despite, or because of their behavior, and can't see the advantage of change. Some people may resist treatment rightly, realizing that the chances for them functioning in a different manner are not good. It is quite possible they have already tried and failed.

It is difficult for certain patients to accept help in dealing with unacceptable behavior because it is the same thing they have been doing for years. If they need treatment now they needed it years ago. Actually it is the tolerance of the environment that has changed for some reason. This tolerance often has served to fix a behavior pattern and make the chance of change remote. At some time in the past some of the same family members now demanding treatment could not accept the uncontroversial evidence that the patient had an emotional inadequacy or weakness.

Refusal of treatment may be participated in by both patient and physician. A particular type of treatment approach may be unacceptable to the patient and the physician may be unwilling to negotiate. The latter may be justifiable but in some cases unorthodox treatment is better than no treatment at all.

Untreated psychiatric illness expresses its morbidity most vividly in the context of family and social situations. One patient who refused treatment on the basis that it would embarrass her family, proceeded to disrupt her husband's work adjustment and her children's school adjustment with minimal concern. The impulsive 20 year old male may defy his parents and ask that they stay out of his life, especially if they're going to suggest such a thing as psychiatric treatment. The family may take him up on it only to find that he and they are unable to break the bonds that hold them—apparently in everlasting, miserable togetherness.

Evidence of considerable subjective discomfort is obvious in some reluctant patients. As a physician it is not easy to accept that what you have to offer is more reprehensible than the patient's current misery. That it is until the offered solution could be made more appealing and promising.

If Patients Still Persist

Despite efforts by referral sources and psychiatrist certain patients will persist in refusing treatment. At this point the physician attempting to accept his medical and social responsibility must exercise caution in demanding conformity to treatment recommendations.[5] After a genuine effort on the part of the physician this responsibility must come to rest on society and its written and unwritten limits on member individuals. Family, school, employer, or court will threaten to ostracize certain patients if they won't accept treatment. This may be done by threats of divorce, termination of financial support, loss of

employment, or consideration of jail sentence. Finally legal commitment for psychiatric care may be obtained. Perhaps it is these oft-considered crude limits that best communicate to the reluctant patient the serious, and maybe hostile, interest others have in him; and the courage they are willing to display in setting limits on what they have realized is behavior detrimental to the patient's health and happiness. If his family or society doesn't care enough to exert these pressures the patient may be justified in questioning the value or necessity of changing his attitudes.

Summary

In a survey of 50 patients refusing psychiatric treatment the majority had no subjective complaints, psychiatric referral resulting from behavior intolerable to others. A variety of diagnostic categories were represented. The patient's deviant behavior or symptoms often had long been tolerated by family members, and in 50% of cases the patient continued to be supported in his refusal of treatment by some family member. Refusal of treatment results from shame, inability to see benefit from changing behavior and fear. The referring source and psychiatrist should use their position to openly promote agreement by family and patient that treatment is needed, as certain patients are able to accept treatment at a later date. Those continuing to refuse are met by inevitable pressures from family, school, employer or by law.

References

1. Guttmacher, M. S.; and Weihofen, H.: *Psychiatry and the Law.* New York: W. W. Norton & Co., Inc., 1952, p. 291.
2. Menninger, K.; Mayman, M.; and Pruyser, P.: *The Vital Balance.* New York: The Viking Press, 1963, pp. 1-8.
3. Committee on Occupational Psychiatry: *The Mentally Ill Employee.* New York: Hoeber Medical Division, Harper & Row., 1965, p. 4.
4. Grinker, R. R.; and Robbins, F. P.: *Psychosomatic Case Book.* New York: The Blakiston Company, Inc., 1954, p. 4.
5. Freedman, L. Z.: "Conformity and Nonconformity," in Hoch, P. H.; and Zubin, J.: *Psychiatry and the Law,* New York: Grune and Stratton, 1955, p. 52.

MOVING SOON?

Let Your IMJ Move With You!

The Post Office will not forward the Illinois Medical Journal from your old address. Make certain you keep getting your Journal by filling in and mailing the form below to: The Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601. Do it now!

Name.....

Old Address.....
(number) (street)

.....
(city) (state)

New Address
(send IMJ here).....
(number) (street)

.....
(city) (state)

CYTOXAN TREATMENT OF KAPOSI'S IDIOPATHIC HEMORRHAGIC SARCOMA

Malcolm C. Spencer, M.D./danville

Awareness of the natural history of many dermatoses makes more difficult evaluation of the effectiveness of any therapeutic response. This is especially true of a variety of the more commonly seen dermatologic problems, e.g., psoriasis, lichen planus, seborrheic dermatitis, even warts and acne, to mention but a few. The same consideration must be acknowledged in the natural course of many of the less common entities encountered, e.g., morphea, lichen sclerosis et atrophicus, granuloma annulare, lichen striatus, etc. On the other hand, there are a number of progressive disorders in which a therapeutic response, when achieved, must be considered as having value. Examples of these would include systemic lupus erythematosus, pemphigus, porphyria cutanea tarta, scleroderma, dermatomyositis, etc.

Kaposi's idiopathic hemorrhagic sarcoma is an uncommon dermatologic problem that, although progressive, may follow a prolonged course because of apparent inactivity. Spontaneous regression with complete clearing, although uncommon, may occur in Kaposi's. This is difficult to evaluate unless it is total, for it may be simply a period of inactivity. Because of these variables a therapeutic response must be assumed as presumptive until several years have elapsed following treatment. The present case report is based on the therapeutic response of Cytoxan (cyclophosphamide) after an interval of five years.

Department of Dermatology, Northwestern University Medical School.

Case Report

J.M., hospital number 3088, a 59-year old Negro male weighing 65 kg., was hospitalized in 1960 for evaluation and treatment of multiple new vascular tumors (15-20) in the skin of each hand and forearm. These had developed during the two months since he was last seen (Figure 1). There were no visceral changes. He had been followed periodically since 1957. It was at this time that the diagnosis of Kaposi's idiopathic hemorrhagic sarcoma was established by biopsy (Figure 2). His original lesions developed on his right hand in 1947. He had been unable to work since then because of the involvement on his right hand.

Prior to 1957 he had been seen by a number of physicians who had treated him with a variety of topical preparations as well as superficial X-ray (amount not established) plus several courses of antibiotics (mainly penicillin).

Since 1957 he had been seen by me at



Figure 1: Pretreatment photograph. Original area on right palm. Recent extension to wrist and forearm. Similar vascular nodules had also appeared on left hand.

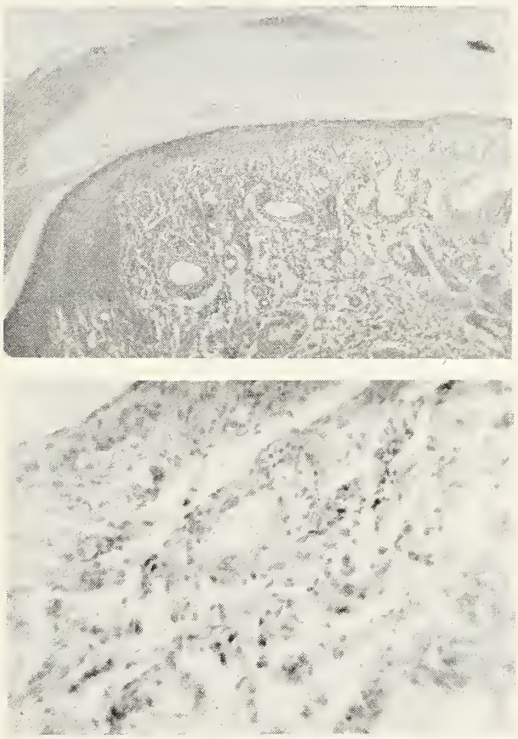


Figure 2: Pretreatment biopsies—100 (top) and 450 X (bottom)—showing the cardinal changes of new capillary formation in the dermis, mainly of blood vessels, with a few lymph vessels and connective tissue hyperplasia.



Figure 3: Post-treatment photograph. Five years after Cytoxan therapy.

irregular intervals (mainly for treatment of secondary infection). During this time he had received a course of 6 million units of penicillin, Bismuth Subsalicylate (11), Fowler's Solution (potassium arsenite solution), 416 r. of grenz ray, and fractional superficial X-ray exposures during a six-week period totaling 1,200 r.

Because of the recent extension of the tumors and the indifference of a therapeutic response with previous treatments, Cytoxan therapy was started. A dose of 200 mgm. daily was well tolerated and was not increased. Weekly wbc and platelet counts, more often when indicated, were done while he was taking the drug. During the next three months he received a total of 9,900 mgms. No abnormal reduction of the white count occurred during this time although the drug was temporarily discontinued when his platelet count was reduced to 134,000. During and following active treatment, a total but temporary defluvium of scalp hair occurred. Within one week after Cytoxan treatment was started, noticeable reduction in the prominence of individual lesions had occurred. This therapeutic response continued during the three months he continued treatment. Gradual disappearance of all residuals of the tumors occurred during the three months after Cytoxan was stopped. Five years later, there was no evidence of recurrence (Figure 3).

Discussion

Multiple idiopathic hemorrhagic sarcoma is no longer regarded as a true malignant sarcoma. However, it may be associated with Hodgkins, leukemia, or lymphosarcoma. Some feel that it is a form of angiomatosis while others hold that it is a reticuloendotheliosis. It has been established that the lesions are all independent and multicentric in origin. There are no metastases except in rare cases when the cells become sarcomatous. The varied histologic appearance of the tumor can be appreciated only if it is recalled that it arises from undifferentiated mesenchymal cells which may form endothelial cells, pericytes, reticulum cells, fibroblasts and histiocytes. That there is a predisposition seems apparent since the tumor develops predominantly in middle-aged and older males of the laboring classes of Italian, Jewish, or Russian descent.[1, 2] A few cases have been reported in the American Negro although it is fairly frequently seen in the Bantu tribe of Africa.[3, 4] The hands, legs, feet and face are sites of predilection. Visceral involvement occurs in 10%.[5]

Kaposi's original description published in 1872 is still valid. "Brownish-red to bluish-red nodules, corn or pea to hazelnut size arise in the skin. Their surface is smooth, their consistency firmly elastic, sometimes erectile, as in a hemangioma."[6] Later nodules and infiltrated plaques may form. Lymphedema may be pronounced. The initial changes may be confused with a variety of granulomas (especially bromoderma, sarcoid or pyogenic granuloma), verruca, stasis dermatitis, elephantiasis, neurofibroma, maduromycosis, and in Africa, with even leprosy.

Cytoxan (cyclophosphamide) was produced for the first time in 1957.[7] Its effectiveness was based on the original work of Gomori who in 1948 reported increased amounts of phosphamidase in malignant tissues.[8] Thus, it was theorized that a phosphamide ester of nitrogen mustard could be converted to an active cytotoxic form within malignant tissue.

The dermatologic use of this compound has been mainly directed in the treatment of mycosis fungoides. The response here has been mainly palliative.[9, 10]

Cytoxan for the treatment of Kaposi's multiple hemorrhagic sarcoma has been limited. The few case reports available have not reported the gratifying result that was observed here.[11, 12] The ineffectiveness of the drug in these patients might, in part, be explained on dosage. In none of the cases reviewed was the total amount more than 4,000 mgms.

References

1. Pillsbury, D. M.; Shelley, W. B.; Kligman, A. M.: *Dermatology*, W. B. Saunders Company, Philadelphia, 1956.
2. Bluefarb, S. M.: *Kaposi's Sarcoma: Multiple Idiopathic Hemorrhagic Sarcoma*, Chas. C Thomas, Springfield, Illinois, 1957.
3. Herring, B. D.: Kaposi's Sarcoma in the Negro, *J.A.M.A.* 185: 540-542, August 10, 1963.
4. Rothman, S.: Medical Research in Africa, *Arch. Derm.* 85: 317-321, 1962.
5. Epstein, E.: Extracutaneous Manifestations of Kaposi's Sarcoma; Systemic Lymphoblastoma, *Calif. Med.* 87: 98-103, August 1957.
6. Shelley, W. B.; Crissey, J. T.: *Classics in*

Clinical Dermatology, Chas. C Thomas, Springfield, Illinois, 1953.
7. Arnold, H.; Boureaux, F. and Brock, N.: Neuartige Krebs-Chemotherapeutika aus der Gruppe der Zyklischen N-Lost-Phosphamidester, *Naturwissenschaften* 45: 64, 1958.
8. Gomori, G.: Histochemical Demonstration of Sites of Phosphamidase Activity, *Proc. Soc. Exper. Biology and Medicine*, 69: 407, 1948.
9. Abele, J. C.; Dobson, R. L.: Treatment of Mycosis Fungoides with New Agent Cyclophosphamide (Cytoxan), *Arch. Derm.* 82: 725-731, November 1960.
10. Van Scott, E. et al: Treatment of Mycosis Fungoides with Cyclophosphamide, *Arch. Derm.* 85: 499, 1962.
11. Bluefarb, S. M.: Case of Kaposi's, *Arch. Derm.* 86: 354, 1962.
12. Potter, B.: Case of Kaposi's, *Arch. Derm.* 89: 622, 1964.

CHEST DISEASES AND NURSING HOMES

The search for chest diseases, especially tuberculosis, in general and mental hospitals and penal institutions, has been accepted and productive. Nursing and convalescent homes and related facilities have been an interesting but somewhat forgotten facet of the total health care treatment program. There are more than 23,000 such facilities in the United States with more than 600,000 beds. In 1962, nursing home construction approached 800 million dollars. With the number of beds increasing at the rate of 24,000 annually this is one of the fastest growing medical and economic problems.

Only recently the health standards for these homes attracted indicated attention. The state of Illinois revised minimum standards and regulations for nursing homes which became effective February 1, 1962, and require that every patient have a physical examination prior to or within 72 hours after admission. The physical examination shall include a statement dated and signed by the physician that the patient is free from communicable diseases, including tuberculosis. Physical examinations also shall be given all patients at least annually.

Most nursing homes are too small to maintain x-ray departments. There also is reluctance on the part of the homes' owners to absorb the cost of x-raying or to pass it on to the resident patients.

DuPage County is one of 102 counties in Illinois, located on the outskirts of Chicago. It is the state's most rapidly growing county, with a population of approximately one-third million.

The DuPage County Tuberculosis Sanatorium Board initiated in August 1962 a chest x-ray screening program for all residents of nursing and convalescent homes of the county.

The data compiled for approximately 1000 resident patients show the importance of continuous studies in detecting unkown tuberculosis, pneumonia, malignancies, cardiovascular diseases, et cetera. It also points up the difficulties encountered in using roentenographic equipment and the need for development of better diagnostic, more economical and lighter equipment by the x-ray industry. *Diseases of the Chest*, June, 1965.

THOUGHTS ON PSORIASIS

William G. Parker, M.D./mount vernon

PSORIASIS IS AN ENIGMA. It does not lend itself to animal experimentation. There is little to indicate that special diets have any etiological significance.

The external manifestations of the disease are the result of an internal disorder. It affects both men and women and therefore is not sex-linked. Text book descriptions and illustrations are well done but no one has come forward with an etiology that is helpful.

Personal affliction and 40 years of observation have afforded some hindsight and perhaps some insight into the possible nature of this disease. It is apparent that psoriasis is not an infectious disease as herpes zoster seems to be although both have external manifestations. It involves the nervous system but this is an effect not a cause. Unlike "shingles" its distribution tends to be bilateral, and as it relates to the spinal nerves may be segmental. I have observed the eruption on both parietal areas of the scalp, both sides of the chest following the intercostal nerve distribution; both sides of the abdomen likewise; both elbows, both knees, both lateral surfaces of the thighs and sides of the calves in the same patient. This would indicate that the spinal cord or ganglia are involved. Unlike the motor cell involvement in polio the distribution is to the skin, and the nerves involved may be the same as those affected in shingles. Interruption of these nerves stops the eruption permanently. I have excised discrete areas of eruption as large as a 50 cent coin with no recurrence in that area for years. I have also made semicircular incisions proximal to discrete areas undercutting the skin and suturing it back in place with a similar result. The idea for doing this was to interrupt the nerve endings as is sometimes done in cases of pruritis ani. Such measures are not practicable in extensive eruptions but shows that the peripheral nerves are affected.

It has been stated that psoriasis never leaves a scar. This is not so as I have seen smooth scar follow the healing of a long-time lesion and years later when the eruption recurred in the same locality the scar resisted the encroachment much longer than the surrounding skin but finally yielded. It is probable that the development of new skin vessels required a longer time to be affected than those already present. It has been said that lesions may occur after minor injuries, even a needle puncture. This is true and may be due to the skin being "sensitized" and the local trauma sets off subcutaneous capillary dilatation, engorgement, hyperplasia of the deeper skin structures, piling up of the squamous elements causing scaling and itching.

When the nails are involved, usually a tender area appears and a small pale spot appears which spreads with loosening of the nail. When the process begins in the nail matrix the nail becomes deformed. When psoriatic arthritis occurs the process in the deeper tissues is probably analogous but no eruption can take place. The result is pain and soreness and swelling.

That psoriasis is a steroid disorder is suggested by the following case history: The patient, a male, had severe urticaria terminating in an exfoliative dermatitis at age 36. This lasted several months. The dermatitis recurred some 12 years later. He had a subdeltoid bursitis a few years later and a second attack of bursitis in the opposite shoulder. At the time of the second attack of dermatitis a transurethral resec-

tion of the prostate became necessary. Several years later a second resection became necessary. An arthritis developed in the wrists and hands and feet. Soon afterward an edema of the macula of the left eye occurred with blurring of central vision. This persisted. At that time this was thought to be due to an embolic process. As salicylate treatment was not effective, injections of adrenocorticotrophic hormone (ACTH) were given with good effect on the arthritis and marked improvement in the psoriasis. However an edema and moderate hypertension followed and the injections were stopped. At times there was some recurrence of the arthritis for which triamcinolone was administered with benefit. The dosage varied from 2 to 8 mg daily. When this was discontinued the patient became weak and exhausted. He had been engaged in some vigorous physical exertion and it seems the exhaustion was due to this combination of circumstances. The exhaustion was accompanied by weakness of the legs and a sensation of extreme depression. At this time an edema of the opposite macula occurred but not as severe as the first. There was the same blurring of central vision. A general physical examination was negative aside from the eruption which had flared. Blood examinations were negative. An x-ray examination of the chest, upper gastrointestinal tract, sigmoidoscopy and barium enema were negative, as was urinalysis and blood pressure (140/80). An electrocardiogram and an electroencephalogram were normal.

The oral steroid preparations are substitution treatments and may cause depression of the gland with a let-down or collapse when discontinued. Injections of ACTH were resumed with much relief from the weakness and improvement in the eruption. It now seems that the retinal edema may be a part of the psoriatic process instead of an embolic one. Because of the beneficial effects of cyanobalamin (B_{12}) in neuritic conditions this was also administered in 1000 mcg doses.

Physicians are aware of the effects of psychic and emotional states on the skin as seen in neurodermatitis, vasomotor changes and even urticaria. That psoriasis may be precipitated similarly is shown in the case of a male patient who had an extensive eruption covering most of the trunk. Fortunately this subsided but a year later he had a recurrence. Asked if he had any anxieties he said he was in business with a brother-in-law who was stealing from the firm and he was in a dilemma as to what to do about it.

Personal and professional experience indicates that psoriasis is a disorder of the suprarenal glands acting through the nervous system. Which of the numerous hormones coming from these structures I have no idea. A physiological chemist might have some idea of how to go about finding out. We do know that the substitution products tend to depress function and to allay the inflammatory process, and when withdrawn diminish the ability to withstand stress. ACTH on the other hand has a stimulating effect and is useful in allergic states. In using it we are not dealing with a perfect weapon and circumspection is necessary. With the substitution products we should be even more cautious.

Local treatment is directed at effects and not cause and should be gentle. Removal of the scales is best done with soap and water and a wash cloth. The red areas beneath the scales are definitely warmer than normal skin. This can only be due to dilatation of blood vessels and the result of a vasomotor relaxation. No application causing irritation should be used. Unless used over extensive areas the steroid creams may be soothing. The clean tar preparations may be used in chronic cases but it is probable they are not very effective unless followed by ultraviolet therapy.

Paraldehyde Acidosis Syndome

Raimonds J. Gailitis, M.D.,
F.A.C.P./chicago

It is very unusual to encounter a patient with a severe metabolic acidosis in whom the etiology of the acidosis cannot be readily established. Some of the more common causes, such as renal disease, diabetes mellitus, and loss of pancreatic juice, are all easily diagnosed by simple clinical and laboratory means. The less common ones, such as renal tubular acidosis, acetazolamide acidosis, hepatic failure, ingestion of methyl alcohol, boric, and salicylic acids do pose more serious diagnostic problems. I am reporting a case of a rare variety of metabolic acidosis (Blood pH 6.8) in which the ingestion of paraldehyde, taken over a period of eight months, was implicated. The patient survived two episodes of almost identical intoxication and made complete recovery despite 3 week mental confusion.

Paraldehyde is a polyether of a cyclic structure with a six-membered ring of three carbon and three oxygen atoms containing no free carbonyl groups. Paraldehyde was thought to be non-toxic and has been used very widely as a sedative and hypnotic in a variety of clinical situations. Although the drug possesses a wide margin of safety, respiratory depression, cardiovascular collapse, local gastric and rectal burns, and recently five cases of very severe metabolic acidosis have been encountered and reported in the literature.[1–4]

This case is the sixth to be reported. The patient had a severe paraldehyde metabolic acidosis with its typical manifestations: delirium tremens-like behavior, extreme hyperventilation, dehydration and vomiting. Mental confusion persisted despite normal blood pH readings for three weeks following institution of i.v. therapy. He was discharged after twelve days still somewhat mentally confused and physically weak. Another identical chain of events took place about one year later, and the patient made complete recovery.

Clinical Assistant Professor of Medicine, University of Illinois; Department of Internal Medicine, Grant Hospital, Chicago.

Case Report

A 67-year old Caucasian male was admitted to the Grant Hospital, Chicago, on January 27, 1964, with severe, continuous epigastric cramps, nausea, muscular tremor, mental confusion and marked agitation of about three days' duration. Apparently for the past eight months the patient had been in rather poor health, suffering from frequent episodes of upper abdominal cramps for which his physician had prescribed 4 ml. of paraldehyde per day. The precise quantity of paraldehyde actually consumed by the patient was more than this, especially in the week preceding his admission. However, the exact amount is unknown. The patient did not drink alcohol at any time. Numerous gastrointestinal x-ray examinations in the past ten years had failed to demonstrate any gastrointestinal pathology. Five years previously a physician had thought he was suffering from chronic pancreatitis.

Physical examination revealed a rather poorly nourished, dehydrated, acutely ill man who was extremely hyperkinetic, purposeless in his movements, confused and

semicomatose. He had an extremely severe hyperventilation. There was a strong odor of paraldehyde on his breath, which persisted for about 72 hours. His temperature was 97.6°F rectally; blood pressure 90/70 mm Hg; and pulse rate 140/min. The respirations were 40/min. and Kussmaul in type. The skin was dark and tissue turgor was extremely poor. The tongue was very dry, cracked and the lips were dry and slightly cyanotic. There was some tenderness in the midepigastrium on deep palpation. However, there was no abdominal rigidity present at any time. The bowel sounds were normal. The deep tendon reflexes were hyperactive. The pupils were small and nonreactive to light. Nystagmus was present. The rest of the physical examination was within normal limits.

Initial laboratory studies revealed a hemoglobin concentration of 19.5 g/100 ml, a hematocrit of 60%, and a WBC of 17,000/mm^3, with a differential of 90% neutrophiles, 8% lymphocytes, 2% monocytes. The urine was very scanty and dark. A sufficient specimen was obtained 10 hours after admission and had a specific gravity of 1.023, a pH of 5.0, ++ albumin, a trace of sugar, 3 + acetone and 5-6 RBC and 4-6 WBC/high power field on microscopic examination. A chest roentgenogram and flat plate of abdomen were negative on admission. As can be seen in Table I, blood studies, obtained six hours after admission, showed severe metabolic acidosis, with a blood pH of 6.8 and a serum carbon dioxide content of less than 4.0 mEq/liter. Serum amylase was 505 units/100 ml. and lipase was 0.43 units/100 ml.

During the first 24 hours the patient received a total of 7,800 ml of intravenous fluids composed of 4,000 ml M/6 sodium lactate, 1,000 ml 10% dextrose in normal saline with 20 mEq potassium chloride added, 2,800 ml 5% dextrose in water. Total urine output was 300 cc in the first 24 hours.

Twenty-four hours following his admission the patient appeared essentially in the same physical and mental condition. He continued to be hyperkinetic, completely confused and exhibited marked hyperventilation, without any evidence of tetanic manifestations.

On the second day (Table I) laboratory studies showed hemoglobin concentration of 12.6 g/ml, and a considerable correction of his acidosis. The urine had a specific gravity of 1.010, a pH of 5.0, 1 + albumin, 4-6 RBC and 6-8 WBC/high power field on microscopic examination. The blood creatinine value was 4.5 mg/100 ml. The blood glucose was 158 mg/100 ml, and SGOT was 28 units. The amylase was 317 units/100 ml. The respirations were 38/min. and still Kussmaul in type. During the second day urinary output improved considerably, although the specific gravity was 1.010. The patient became weak and developed shock-like picture with blood pressure 80/60 mm Hg. 1000/ml normal saline with 50 mgm Solu Cortef were administered with good results. Also 50 g of Mannitol were given to improve urinary output early on the second day. On the third hospital day mild hypokalemia with hypernatremia occurred and was successfully corrected with i.v. fluids (see Table I).

Four days after admission the blood chemistries were near normal with a blood pH of 7.35. At this point breathing became more shallow and the mental confusion still persisted. Liver function was essentially normal with negative cephalin flocculation. BSP retention was 9% in 45 minutes. Prothrombin time was normal and the cholesterol was 285 mg/100 ml.

On the fourth, fifth, and sixth hospital days temperature increased gradually to reach 104.5° F rectally. The patient was able to take some oral nourishment. The temperature returned to normal by the eighth day. A creatinine clearance on the sixth day was 52 ml/min showing some impairment of kidney function. Throughout the rest of his hospital stay the patient showed good response to therapy; however, he remained mentally confused even after his discharge on February 10, 1964. The patient made very satisfactory progress at home, and was mentally and physically fit.

On discharge the blood chemistries were essentially normal except for a BUN of 54 mg/100 ml.

The patient was readmitted to the Grant Hospital, Chicago, on April 26, 1965. His

TABLE I

DATE	Hb g/100 ml	Hct Vol. %	WBC mm^3	Intake ml	Output ml	Creatinine mg/100 ml	BUN mg/100 ml	Na	K	Cl	CO_2	pH
1st admission												
1/27/64	19.5	60	17.000	Total intake 7800 of which 4000 was M/6 sod. lactate Hydrocortisone 200 mg Mannitol 50 grams Urea 30 grams	300	3.4	45	134.0	5.0	113.0	<4.0	6.8
1/28/64	12.6	37	14.000	3500	2760	4.5	156	134.0	3.3	102.0	21.2	..
1/29/64	..	..	..	2200	3500	2.8	92	150.0	2.7	101.0	29.4	7.35
1/30/64	..	..	..	..	..	..	..	147.0	3.4	111.0	30.0	7.35
2/1/64	..	..	..	..	..	1.8	54	138.0	3.7	108.0	21.8	7.35
2nd admission												
4/20/65	19.0	58.0	26.000	5000 M/6 sodium lactate	950	4.2	33	125	4.2	99.0	2.6	6.88
4/30/65	12.2	34.0	8.200	..	1400	2.1	20	134	5.4	102.0	20.6	7.5

symptoms were essentially the same. They have followed rather continuous intake of paraldehyde over a period of about three weeks.

Physical examination revealed a rather emaciated, dehydrated, acutely ill man who was extremely hyperkinetic, purposeless in his movements, constantly trying to draw up his knees. Most of the time he showed an extreme degree of hyperventilation and was semicomatose. His temperature was 97.8° F rectally. The blood pressure was 95/65 mm Hg; and the pulse rate 128/min. The tongue was very dry and cracked. No abdominal rigidity was present although there was tenderness over the midepigastrium.

The laboratory studies revealed a hemoglobia concentration of 19.0 g/100 ml, a hematocrit of 58 volume %, a W.B.C. of 26.000/mm^3, with normal differential count. The urine was dark and ++ albuminuria was present. The specific gravity was 1.020 with negative microscopic findings. The blood studies showed severe metabolic acidosis, with a blood pH of 6.88, and a serum carbon dioxide content of 2.6 mEq/liter. Serum amylase was 250 units/100 ml. and serum lipase 2.7 units/100 ml. (Normal 0.2-1.0 units/100 ml.) The blood creatinine was 4.2 mg/100 ml., the blood urea nitrogen 33 mg/100 ml., the calcium 8.7 mg/100 ml., the serum sodium was 125 mEq/1, the serum potassium 4.2 mEq/1, the chloride 99 mEq/1. Urinary diastase in 950 cc. urine (29 hrs.) was slightly elevated to 3658 units. The total lips in serum was elevated to 1580 mg/100 ml. The patient was given 5000 cc M/6 sodium lactate during first 20 hrs. of his hospital stay.

The blood pressure and respiration returned to normal, however, pulse rate was about 100 per minute. The serum carbon dioxide content was up to 6.5 mEq/liter on the following day. The blood pH was 6.88, however. The patient was able to take nourishment orally and was discharged 6 days later. He still showed almost complete loss of memory and was totally confused. Some three to four weeks later he showed almost complete mental and physical recovery.

Discussion

Since paraldehyde is a rather common sedative and has been in use for many years, it is surprising that so few cases of paraldehyde acidosis have been reported. Acute paraldehyde intoxication may lead to death, but in humans it has only been reported as resulting from the effects of respiratory depression or direct caustic actions.[5,6] It is thus probable that for this severe metabolic acidosis to occur, certain predisposing factors might be required.[7,8,9] An examination of the other five cases which have been reported demonstrates some common findings.[1,2,3]

There is a very close correlation between this case and four of the others. In each there was a chronic intake of paraldehyde with a period of two to four days prior to admission, in which nausea and vomiting ensued, though paraldehyde intake continued. The patients were all noted to be dehydrated upon admission. Only one patient was considered well nourished.

Besides the history of chronic ingestion of paraldehyde with a recent increase in total daily quantities consumed, there were no other common factors reported. Two patients were chronic alcoholics, two were primarily psychiatric problems without alcoholism and the case here reported was suffering from recurrent pancreatitis. However, four of the five patients had either gross or occult blood in their emesis by the day of admission. They also had leucocytosis, mostly neutrophiles (37,200; 24,800; 65,400; 47,400; 17,000). Their temperatures were not unusual (100, 96^r, 98^r, 98, 97.6^r) and the urine specimens when obtained early, were concentrated, acid, and had various nonspecific findings, suggesting no gross renal insult.

The more severely affected patients were delirious and stuporous upon admission, and had abdominal pain, accompanied in some instances by rigidity and tenderness throughout the abdomen. Clinically the present patient's abdominal symptoms during both emergency admissions suggested an attack of pancreatitis.

Two patients were thought to be in acute renal failure and one was treated with peritoneal dialysis and the other placed on the artificial kidney. My patient however, had received 7,000 ml of fluid in 18 hours and had a urinary output of 300 ml or 950 ml. respectively (2nd admission). The initial Hg of 19.5 gm/100 ml and a hematocrit of 60% dropped in 24 hours to 12.6 g/100 ml and 37% respectively. The severe acidosis was sufficiently corrected with 4,000 ml of M/6 sodium lactate in both instances. 50 mgm Solu Cortef in saline were required to treat the low blood pressure encountered during the first two days in hospital.

The possible causes of this type of acidosis have been discussed by the authors.[1,2,3] No specific defect in metabolism of paraldehyde has been implicated by them. Though partially decomposed paraldehyde contains acetic acid, this quantity would still be insufficient to account for the massive quantities of excess H^+ that were circulating in the blood.[5]

A defect in lactate metabolism is also ruled out, since in this case it was given as the sole source of bicarbonate ion and the patient made an uneventful recovery. Elevated levels of lactate were found only in one case and there were no changes in the lactate/pyruvate ratios.[1,2,3]

It is possible that this severe acidosis is the result of paraldehyde or its metabolic by-products, which accumulate in toxic concentration only in the severely dehydrated patient who is chronically ingesting paraldehyde. It may be that in the well hydrated patient only the effects of the direct caustic action or respiratory depression ensue. The massive doses of lactate or bicarbonate that are required to correct this acidosis imply that more than just kidney failure must be involved, since complete anuria will not cause such severe acidosis so quickly. Thus the paraldehyde and/or its derivatives should be involved in a manner that is causing generation of acid, not merely failure to excrete it.[10,11,12] Insulin was of no effect in the treatment of one case, and no significant increase in acidic derivatives of fatty acid oxidation were found in any of the other cases. No specific elevation of a conjugate base for the excess H^+ has been demonstrated. However, many of the various potential conjugate bases have not been measured.

Summary

The sixth case of a paraldehyde acidosis syndrome is presented. This patient had two similar attacks 16 months apart. The common denominators of this syndrome appear to be:

a) chronic ingestion of paraldehyde;
b) a period of two to four days of anorexia, nausea and vomiting;
c) dehydration;
d) guaiac positive vomitus;
e) severe metabolic acidosis;
f) abdominal pain;
g) mental confusion
h) extreme restlessness with purposeless movements.

The patients may appear to have an acute abdomen with pain, nausea and vomiting and a high white blood count, but the odor of paraldehyde on the breath and the severe air hunger make the clinical diagnosis apparent. Treatment requires extensive rehydration and restoration of acid-base balance.

No specific metabolic sources have been identified for the severe acidosis. It is assumed that by chronic ingestion paraldehyde or one of its by-products may attain sufficient concentration in the dehydrated patient to cause enzymatic changes, leading to the active and excessive production of acids. The paucity of reports of paraldehyde acidosis suggests that certain genetic or acquired enzyme states may predispose a patient to this condition.

References

1. Hayward, J. N., Boshell, B. R., Paraldehyde Intoxication with Metabolic Acidosis, Report of Cases. Experimental Data and Clinical Review of the Literature, *Amer. J. Med.*, 23:965, 1957.
2. Elkinton, J. R., Huth, E. J., Clark, J. K., Barker, E. S., Seligson, D., Renal Tubular Acidosis with Organic Aciduria during Paraldehyde Ingestion, *Amer. J. Med.*, 23:977, 1957.
3. Waterhouse, Ch., Stern, E. A., Metabolic Acidosis Occurring During Administration of Paraldehyde, *Amer. J. Med.*, 23:987, 1957.
4. Agrant, A. L. and Trubshaw, W. J. D., The Danger of Decomposed Paraldehyde, *South Africa M. J.*, 29:1021, 1955.
5. MacFall, J. E. W., Paraldehyde Poisoning, *Brit. M. J.*, 2:255, 1925.
6. Levine, H., Gilbert, A. M. and Bodansky, M., The Pulmonary and Urinary Excretion of Paraldehyde in Normal Dogs and Dogs with Liver Damage, *J. Pharmacol. & Exper. Therap.*, 6a:316, 1940.
7. Levine, H., Gilbert, A. J. and Bodansky, M., The Effect of Liver Damage on the Blood Level and Action of Paraldehyde, *J. Pharmocology & Exper. Therap.*, 67:299, 1939.
8. Gardner, H., Levine, H. and Bodansky, M., Concentration of Paraldehyde in the Blood Following Its Administration During Labor, *Am. J. Obst. & Gynec.* 40:435, 1940.
9. Taylor, F. H. L., Weiss, S., Wilkins, R., The Bisulfite Binding Power of the Blood in Health and in Disease with Special Reference to Vitamin B. Deficiency, *J. Clin. Invest.* 16:833, 1937.
10. Hitchcock, P., Nelson, E., Metabolism of Paraldehyde, II, *J. Pharmacol. & Exper. Therap.*, 79:286, 1943.
11. Solman, T., Studies of Chronic Intoxications on Albino Rats, III: Acetic and Formic Acids, *J. Pharmacol. & Exper. Therap.*, 16:463, 1921.
12. Beier, L. S., Pitts, W. H., Gornick, H. C., Metabolic Acidosis Occurring During Paraldehyde Intoxication, *Ann. Int. Med.* 58:-155, 1963.

A PROFILE OF DR. HIRSCH AS A HUMANIST

Samuel A. Levinson, M.D./chicago

It is a privilege for me to be afforded the opportunity of honoring Dr. Edwin F. Hirsch, pathologist, scientist, scholar, patron of the arts and, above all, humanist.

Raised in an atmosphere of learning, Dr. Hirsch was born in Charles City, Iowa, the son of J. Patrick Hirsch, president of Charles City College. Later, this college affiliated with Morningside College and it was from this institution that Dr. Hirsch received an honorary degree of Doctor of Science in 1955.

Dr. Hirsch received his education in Chicago: B.A. from Northwestern; M.S. from the University of Illinois; Ph.D. in pathology from the University of Chicago; and, finally, his M.D. from Rush Medical College in 1916.

At the University of Chicago, Dr. Hirsch came under the guidance of Professor H. Gideon Wells, chairman of the Department of Pathology. Later, there was continuing development in scientific and cultural areas in an environment which was most unique in Chicago at that time. Dr. Hirsch's internship training at Presbyterian Hospital brought him in contact with Dr. Frank Billings. Others, equally famous in the sciences and biology, who encouraged Dr. Hirsch were Christian Fenger, Ludvig Hektoen, Edwin R. LeCount, James B. Herrick and many, many others.

For 40 years Dr. Hirsch was pathologist at St. Luke's Hospital, where he organized the department, introduced newer methods in anatomic and clinical pathology, instituted a training program for residents in pathology and an educational program for the house and attending staffs. Many of you may recall that the Clinical Pathological Conferences, when scheduled at 11 o'clock in the morning, began promptly, whether there was one person attending the conference or the amphitheatre was crowded.

Then for 35 years, Dr. Hirsch was secretary of the Chicago Pathological Society, succeeding the first secretary, Dr. George Weaver. I do not know of any organization in this country in which a man served for as many years in the capacity of secretary and developed the educational program that Dr. Hirsch accomplished during his tenure.

How stimulating the programs were was manifest by the inspiration the younger pathologists received when they attended the meetings of the Chicago Pathological Society. In the audience were men like Drs. Christian Bay, James E. Herrick, Ludvig Hektoen, H. G. Wells, Maud Slye, E. R. LeCount, David John Davis, James P. Simmonds, Esmond Long, William F. Peterson and Richard H. Jaffe, along with other outstanding surgeons and internists. We, as young fellows who attended these

meetings, were stimulated just to be in the presence of these giants of medicine.

I will not discuss the research in the sciences that Dr. Hirsch contributed, except to direct your attention to the fact that, at this very moment, he is continuing his research activities in a series of articles concerning the innervation of the heart, the most recent of which were published in the January 1965 issue of "Archives of Pathology." However, I do want to comment very briefly on the activities of Dr. Hirsch as a humanist, in the area of para-professional activities.

Reorganizes Resident Program

Dr. Hirsch was active in the reorganization and educational training program for residents in pathology at Provident Hospital. Many Negro residents received their training, not only at Provident under the guidance of Dr. Hirsch, but also at St. Luke's. He worked with Dr. McLean and a committee from the Institute of Medicine on developing a program for acceptance of Negro students and other minority groups in our medical schools, as interns and residents in our hospitals, as attending physicians on our hospital staffs, and the acceptance of Negro and other minority groups as patients in our hospitals. Dr. Hirsch is a member of the Mayor's Commission on Human Relations. I do not know of any appointment on any committee in the biological sciences, humanities or the arts on which he did not work diligently and effectively, with enthusiasm in his quest for justice and without compensation.

During the past 20 years, Dr. Hirsch has been appointed by various governors to the Advisory Board of Cancer Control. He has also served as a member of the Citizens' Committee to Study Cook County Hospital and as chairman of a committee to investigate the overload of obstetrical patients at Cook County Hospital. In these latter capacities, Dr. Hirsh, working with the Rt. Rev. Monsignor John W. Barrett and Dr. Morris Fishbein, formulated a program for the Cook County area hospitals to receive the overload of obstetrical patients which was adopted by the Chicago Hospital Council.

Let me cite another example. Some years ago there was established a Citizens' Committee, including the deans of the Chicago medical schools, to improve the scientific status of the Cook County Coroner's Office. Dr. Hirsch and I were asked to serve on this committee, under Dr. Lowell Coggeshall as chairman. Several outstanding and prominent citizens of the Chicago area were named to this committee and many meetings were held. Two subcommittees were appointed with Dr. Hirsch as chairman: one to study the scientific aspects of the Coroner's Office and another to consider the architectural reconstruction of the Cook County Morgue's proposed facilities. He was also active on the subcommittee which met with the Cook County Board of Commissioners to obtain funds for these projects. This subcommittee successfully obtained $250,000 from the Commissioners as well as a bond issue to remodel the antiquated morgue.

Dr. Hirsch and the architects worked out the plans for the renovated morgue, which included remodeling the second and third floors for toxicology and research. Dr. Karl Meyer and the Cook County Commissioners agreed that when the new Hektoen Institute was completed, the Cook County Morgue would become the Institute of Forensic Pathology and an integral part of the Coroner's Office.

Locates Coroner's Pathologist

When the Citizen's Committee, with the approval of the Cook County Commissioners, recommended the appointment of a full time Coroner's Pathologist at the Morgue, it was Dr. Hirsch who was asked to locate a board-certified physician for this post. He then organized a postgraduate training program for interns, residents and physicians in forensic pathology at Presbyterian-St. Luke's Hospital. When the Coroner's Pathologist resigned from his post, the Citizens' Committee, with the approval of the Coroner, called on Dr. Hirsch to act on a consultative basis in pathology and scientific study, for the Coroner's Officer. Dr. Hirsch still retains this position, pending the appointment of a permanent staff of pathologists at the Institute of Forensic Pathology. This is an example of a dedicated individual who, with many added duties and responsibilities superimposed on an already heavy

schedule, always found the time and energy to give of himself as a citizen, scientist, scholar and humanist to society.

A progressive group of funeral directors in the Chicago area apprised the pathologists that a large segment of their organization was opposed to post-mortem examinations. When no action was taken by our colleagues, Dr. Hirsch was approached and he asked me to join him in the organization of a mutual understanding between the Funeral Directors Association and the pathologists in the greater Chicago area. We organized an interprofessional group composed of representatives of the Chicago Pathological Society, the Institute of Medicine of Chicago, the Chicago Medical Society, the Chicago Hospital Council and the Chicago Funeral Directors Association. We published two brochures on "Manual of Procedures upon the Occurrence of Death in Hospitals of the Chicago Metropolitan Area." The differences between the various groups were resolved, but this interprofessional committee is still active and its program has been accepted by many communities in this country.

Improves County Coroners

With the late Dr. Oscar Schultz and Dr. Ludvig Hektoen, I had the privilege, as the representative of the Chicago Pathological Society and the Institute of Medicine, to present to the Illinois State Legislature a bill to replace the coroner system with the medical examiner system. We had the assurance of Governor Henry Horner that if the bill was passed by the legislature he would sign it. Unfortunately, the legislature did not pass the bill. Later, Dr. Hirsch, with the consent of the Citizens' Committee, undertook again this phase of improving the pathologic and scientific aspects of the 102 county coroners and Coroner's Pathologists in Illinois.

To repeal the constitutional act concerning the Coroner's Office is almost impossible except by a referendum. But Dr. Hirsch projected this program from the Cook County area to a statewide basis by introducing a bill to the state legislature, spelling out the function of the Coroner's Office and the pathologists. He organized, also on a statewide basis, a committee to obtain the cooperation of the coroners of the 102 counties and the funeral directors in Illinois. Dr. Hirsch and I made frequent trips to Springfield at the request of the Senate Committee to speak in favor of this bill. It was passed by the legislature but, unfortunately, was vetoed by Governor Stratton in 1955. Dr. Hirsch continued his efforts, however, and two years later a revised bill was again introduced to the legislature. It was unanimously approved and signed into law by the Governor.

A committee of nine was appointed by Governor Stratton consisting of Dr. Hirsch as chairman, three Coroner's Pathologists, three lawyers and three non-professional people. It was known as the "Advisory Board on Necropsy Service to the Coroners of Illinois." Dr. Hirsch wrote three manuals on the medico-legal autopsy, which were published by the state and distributed to every hospital and pathologist in Illinois. He was instrumental in establishing a Toxicology Department as a division of the Illinois State Health Department and in 1959 the state legislature appropriated $200,000 to develop one branch in Chicago and another in Springfield.

Dr. Hirsch was secretary of the Chicago Pathological Society for 40 years. For some years I was treasurer of this society, having succeeded Dr. Alfred Goldsmith. When Dr. Hektoen died, Dr. Hirsch said to me "I want to establish a special memorial for Dr. Hektoen, quite different from the usual annual lectures and I suggest that the Chicago Pathological Society establish the 'Hektoen Commemorative Services' to be held at the Hyde Park Baptist Church, where Dr. Hektoen was a member." This was to be a presentation of choral and orchestral music. Dr. Hirsch's idea was approved by the Chicago Pathological Society.

A Tribute to Mrs. Hirsch

At this point I must pay tribute to Mrs. Helen Hirsch, wife of Dr. Hirsch, a professional musician of extraordinary ability and at one time principal French horn player with our Chicago Symphony Orchestra. At present she is principal French horn player with the Civic Opera Orchestra. Dr. and Mrs. Hirsch undertook the de-

velopment of this program for the Hektoen Commemorative Services. She obtained members of the Chicago Symphony Orchestra, soloists, and members of a choir. This program was instituted in 1953 and continued every year until 1961. Those of you who attended these services will concur that they were an exemplary professional presentation to commemorate Dr. Ludvig Hektoen.

In 1959 Dr. Hirsch was elected president of the Chicago Pathological Society. For 40 years he was a Fellow of the Institute of Medicine of Chicago and for more than 12 years a member of its Board of Governors. He received the second George Coleman Medal and Award from the Institute of Medicine in 1961, and is still active in the Institute, as Editor of its "Proceedings." He has received many awards and honors from various scientific organizations.

Dr. Hirsch was secretary for six years and later president of the Section on Pathology and Physiology of the American Medical Association. He was also president of the Chicago Medical Society and is presently a member of its Board of Trustees.

I have been a lifelong friend and colleague of Dr. Hirsch. In summary, one might ask of Dr. Edwin F. Hirsch: What is the way of a man dedicated to his work and to society? What is the way of true worship?

Permit me to reply in the words of the Hebrew prophet, Micah:

"And what does the Lord require of you
But to do justice and to love kindness
And to walk humbly with your God."

PROBLEMS WITH DISPOSABLES

The increased use of disposables in hospitals has contributed to many problems in the area of marketing. The use of disposables has resulted in larger volumes of supplies to be transported and stored, increasing the cost of both functions. The hospital using disposables must have close, frequent contact with manufacturers' representatives for the purpose of solving the problems that might arise and to teach personnel the proper use of their products. In addition to larger numbers of representatives, there must also be more research at the using level.

Much has been said about the need for standardization and simplification of hospital supplies to reduce costs in both production and distribution. Industry has been especially vociferous in expressing the need for this, but so far very little has been done. The standardization of supplies and equipment would not only reduce transportation and storage costs but would also save the time of buyers and sellers. One can readily visualize the possibilities in this area for just those items classified as surgical dressings. Surgical sponges are offered to the customers in any size and description one can imagine and are usually purchased to suit the whim of the person who uses them. *Hospitals*, December 1, 1965.

THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital



Fig. 1



Fig 2

(18 min. after rapid injection IV of 500 cc. of saline with 40 grams of urea).

A 30-year-old Negro female entered the Cook County Hospital for evaluation of severe hypertension of three years' duration. A sympathectomy two years ago caused no permanent drop in blood pressure. Her complaints were limited to increasing fatigue and severe headache.

Physical examination revealed a blood pressure of 220/140 mm. Hg. A grade III Keith-Wagner retinopathy was noted on fundoscopic examination. Urinalysis revealed 2+ albumin and an occasional red cell.

What is your diagnosis?

(answer on next page)

(continued)



Fig. 3



Fig. 4

Diagnosis: Renal Artery Stenosis

On a routine IVP (Fig. 1) the following findings are suggestive of renal or artery stenosis as a cause for hypertension:

1. The right kidney is 2 cm. smaller than the left.

2. There is hyperconcentration of contrast material in the right side, even after washout (Fig. 2). The excessive sodium and water reabsorption, which occurs on the involved side in unilateral renal artery stenosis, leaves a far more concentrated amount of the non-reabsorbed contrast material behind to produce this increased density. This is graphically demonstrated by the washout, which indicates a slower urine flow and increased concentration of iodine on the involved side.

3. Conversely, the involved kidney will visualize later than the normal side, which is demonstrated by doing a 1, 2, and 3 minute study. An inspection of the delayed film on the arteriogram (Fig. 4) shows a beginning nephrogram on the left and none on the right. At 3 minutes, a well visualized pyelogram was seen on the left, and a nephrogram was visualized on the right.

4. Lessened volume of contrast material on the involved side (spastic infundibulum and small pelvis).

5. Notching of the ureter and kidney pelvis due to enlarged collateral circulation.

The arteriographic study, following injection of 40 cc. of sodium iothalamate (66.8%) through a catheter placed above the level of the renal arteries, revealed complete occlusion of the right renal artery (Fig. 3), with delayed collateral circulation extending in a retrograde manner through the lumbar arteries, internal iliac and capsular anastomoses to fill the markedly narrowed renal artery beyond the area of occlusion.

The patient's blood pressure has been normal for a period of one year following nephrectomy.

REFERENCE

1. Love, L.: Roentgenology Seminar, *Chicago Medical School Quarterly*, Vol. 25, #2, pp. 79-82, Summer 1965.



UNUSED MEASLES VACCINE AVAILABLE

Illinois physicians and residents may be in for an unfortunate and preventable epidemic of measles, in the face of ample unused Health Department supplies of vaccine, purchased at the request of the physicians themselves.

Last year, on the recommendation of the Illinois State Medical Society and the Illinois Chapter of the American Academy of Pediatrics, the Illinois Department of Public Health purchased about 180,000 doses of measles vaccine for use by clinics and by private physicians. As of February 1, 1966, about 80,000 doses of this vaccine remained unrequisitioned and will be outdated if not used prior to May 1, 1966.

Over 1,976 cases of measles were reported during January of 1966, and this is a higher total than reported during any January since 1962. Thus, this spring will probably be a peak measles season unless efforts on immunizations are increased.

The Committee on Infectious Diseases and Immunizations of the Illinois Chapter of the American Academy of Pediatrics, recently polled by its Chairman, Dr. Edward Press, has recommended that all Fellows of the Academy, as well as all other physicians whose practice includes infants and children, intensify and expand their efforts at immunizing susceptible patients against measles.

The Illinois Department of Public Health has available for free distribution to Illinois physicians about 80,000 doses of measles vaccine of the Edmonston strain, together with immune globulin for concurrent administration.

For large pediatric practices or clinics, the vaccine is packaged in 30 dose units, each unit consisting of six dose vials of the vaccine, diluent, one 10 cc. vial of immune globulin, and 60 disposable syringes. For smaller pediatric practices, or for the general practitioner, it is packaged in smaller units consisting of 5 individual dose vials of the vaccine, diluent, one 2 cc. vial of gamma globulin, and 10 disposable syringes. The vaccine requires refrigeration space, but not freezer space for storage.

The vaccine may be obtained directly from Local Health Departments in those areas of the State where there is a full-time Health Department. In other areas, the vaccine may be obtained by writing or telephoning the Bureau of Epidemiology (Communicable Disease Control), Room 500, State Office Building, Springfield, Illinois, 62706 (telephone 525-2166).

Edward Press, M.D., Chairman, Committee on Infectious Diseases and Immunization, Illinois Chapter, American Academy of Pediatrics.

PLEASE LABEL AS TO CONTENTS

An editorial which appeared in the January 23, 1965 issue of *Chicago Medicine* under the title "Timely Advice," noted that Irving Rubin, pharmacist and editor of the *American Professional Pharmacist*, had six convictions related to the inadvisability of placing drug names on a prescription label. Rubin suggested that labelling of a medication might oversimplify the processes of diagnosis. Additional reasons cited concerned adverse drug reactions and toxicity and that knowing the nature of the medication enables the patient to put pressure on the physician. The possibility of self-medication or "shopping" for prescription medication according to the price were also given as reasons. The editorial concluded "Mr. Rubin has had a long time behind the counter to observe these things. When he tells us that we may lose control of the therapy in a given case, he makes a point of which we may well take note."

That this conviction is not shared by many physicians is evident. Montgomery, writing in the *Annals of the District of Columbia*, October 1964, noted that five words—Please Label As To Contents—on every prescription blank can avert confusion, help the patient understand his illness and treatment more fully, and provide physicians with readily available information as to the nature of current treatment. Dr. Montgomery correctly notes that it is hard for physicians to keep track of all of the medications a patient may be taking; the colors and shapes are sometimes very similar, although the ingredients may be quite different. Knowing the nature of prior medication is useful if emergency medical care is required. However, unless specifically requested, pharmacists are not permitted to label prescriptions.

A leading article "The Anonymous White Tablet," in the August 7, 1965 *Lancet*, dealt with the problem of establishing identity of the unknown tablet or capsule. Attempts have been made to set up a central index with special symbols for the 30 or so small white tablets which would otherwise be difficult to identify. This system leads to somewhat better identification, but is still not 100% accurate. The Joint Committee of the British Medical Association and The Pharmaceutical Society pointed out the difficulty in systematically coding tablets and capsules on a national scale.

A third method of identification is that of a label placed on the drug container by the dispenser. Although it is B.M.A. policy that containers be labelled with the name of the drug unless the prescriber requests otherwise, actually containers are not labelled unless specific instructions are given. Although compulsory labelling is unlikely to win much support, they find it hard to understand why there has been such protracted opposition to labelling unless otherwise specified.

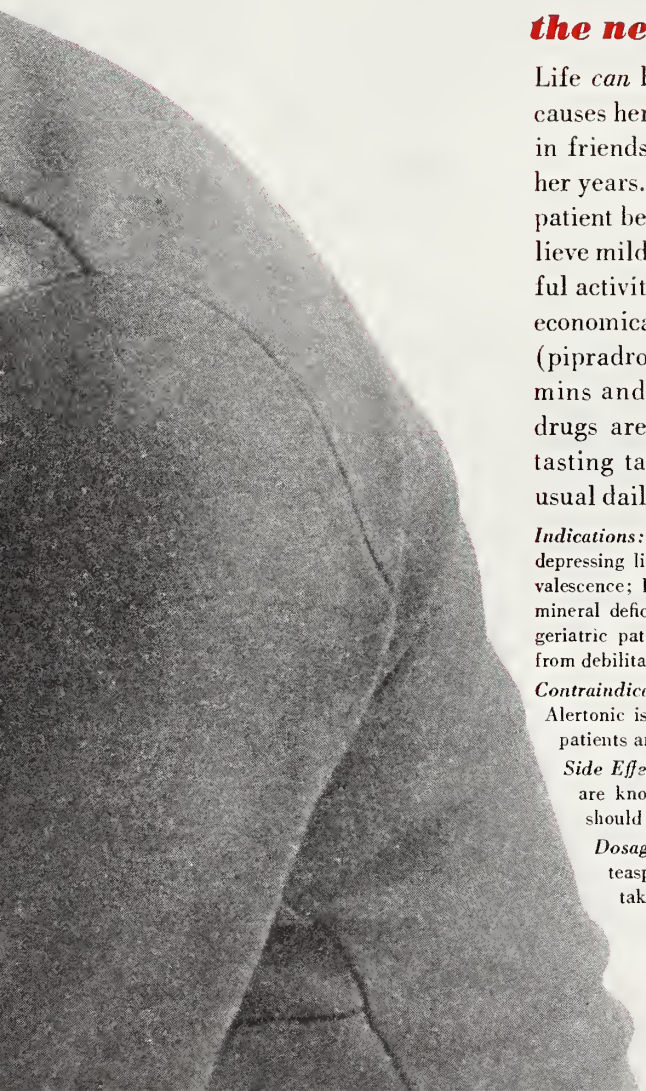
The use of coded medication identified as to the manufacturer and as to the nature of its contents has become more common on both sides of the Atlantic. Both the *Journal of the American Medical Association* and the *Physicians' Desk Reference* have provided information enabling the physician to identify certain products by their appearance. However, to this observer, there is much to be gained in most instances by labelling the nature of the medication. Patients are bombarded on all sides by medical information; their approach to medical care is much more sophisticated than that of their parents. The growth of effective pharmaceutical agents has been such that three or four types of medication may be indicated for the management of a single problem. Labelling promotes better medical care rather than detracting from it. Labelling also promotes more effective communication between the patient and the physician. Labelling of medication is of great help in determining whether inadvertent ingestion of a drug by a child need be a cause for real concern. Not all pharmacists follow instructions regarding labelling even when directed to do so. Perhaps the admonitions of Mr. Rubin and the *American Professional Pharmacist* take precedence over the dispensing directions of the physician. It is to be hoped that such is not the usual situation, as a strong case can be made for the labelling of medication except in rare instances where this procedure would be unwise. It is pleasant to report that the Council on Drugs of the American Medical Association (*J.A.M.A.* 194:1311, 1965) assumed a similar posture.

E. Clinton Texter, Jr., M.D.

revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

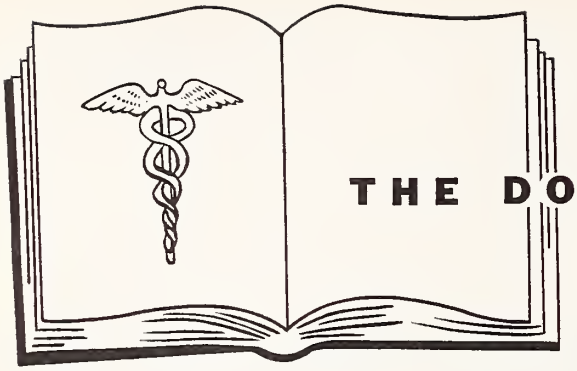
Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio/Weston, Ontario

Merrell



THE DOCTOR'S LIBRARY

STUDIES ON THE ABDOMINAL INCISION. Mathew W. Kobak. Springfield, Illinois, Charles C Thomas, 1965.

Doctor Kobak has had a wide experimental and clinical experience with abdominal incisions, and it is from this fund of knowledge that the material for this monograph has been collected.

The author first describes briefly the history of the abdominal incision. He then discusses the nature of wound healing from an anatomic standpoint. While the complex biochemical changes which occur within a wound are omitted, its structural realignment is described in detail.

In subsequent chapters Doctor Kobak discusses many of the individual variables which influence the healing of an abdominal wound. Thus the anatomic location of the incision, the relative strength of the tissues of the abdominal wall, the physical properties of various types of suture material, and the manner of placing sutures are all carefully considered. Although many of the experiments cited were performed on small mammals, or under in vitro conditions, the author is careful to point out the discrepancies which may occur when applying this information to clinical situations.

The author has personally reviewed the cases of abdominal incision disruptions at Grace-New Haven Hospital from 1940 to 1948 and Michael Reese Hospital from 1947 to 1956. His observations are compared with those reviewed from the literature. The causes of wound disruption are analyzed and correlated with the experimental and theoretical evidence discussed in the earlier chapters. Despite the fact that experimental evidence suggests that the use of strong suture materials and transverse incisions would decrease the number of wound dehisences, the author points out that such is not the case in clinical practice. He wisely concludes ". . . that system giving the best results in a seasoned surgeon's hand probably is the most suitable for his use."

While this book does not nor is it intended to offer a panacea for the prevention of wound dehisence, it does summarize much of the available information, both experimental and clinical, on the nature of abdominal incisions, and thereby should stimulate and interest every surgeon.

Stuart M. Poticha, M.D.

CURRENT SURGICAL MANAGEMENT III. Edwin H. Ellison, M.D., Stanley R. Freisen, M.D. and John H. Mulholland, M.D. W. B. Saunders, Philadelphia, London, 1965, pp. 519.

The authors have called upon an impressive group of contributors to supply alternative viewpoints on a variety of controversial surgical problems. They point out that while surgeons may agree upon the objective of therapy, there may be considerable difference in the approach. The book emphasizes once again that while the education of the surgeon may require a dogmatic approach, embodying the principle that one sound method must be mastered, "maturity brings the realization that there is no one perfect way."

Alternative methods are presented for the management of early and late esophageal carcinoma, carcinoma of the breast, severe non-penetrating chest injuries, cholecystitis, choledochal cyst, acute and chronic pancreatitis, the Zollinger-Ellison Syndrome, acute suppurative parotitis, hiatus hernia, hemorrhage and ascites from portal hypertension, gastroduodenal ulcer disease, mesenteric arterial occlusion, familial polyosis, ulcerative colitis, congenital megacolon, villous adenoma of the rectum and colon, inguinal hernia repair, and thrombophlebitis.

The presentations represent a rare compilation of current thought regarding the alternatives available in a variety of important surgical problems. The book is well organized and its approach provides a large amount of up-to-date information which is easily assimilated. It represents a valuable addition to the surgeon's library and would be an ideal gift for the surgical house officer.

M. C. Anderson, M.D.

(continued on page 280)



Are doctors people?

Lately, Doctor, we've had rather heartening evidence that physicians sometimes act like human beings (such as prescribing for *themselves* two or three ounces of California wine in the control of hypertension, cardiovascular tendencies, cantankerousness, or other problems).

In fact, recently we offered you our expensive, beautiful but underpriced cookbooks "FAVORITE RECIPES OF CALIFORNIA WINEMAKERS" and the new "ADVENTURES IN WINE COOKERY BY CALIFORNIA WINEMAKERS." Both $2 per copy postpaid. Your doctorly response, bless you, was a polite but generous landslide.

We're selling wine cookbooks to doctors like crazy. You like good food, and so do your wives, it appears.

So, may we again modestly offer you the world's most unusual cookbooks, for home enjoyment or gifting? Just drop us a note on your professional letterhead, with as many two-dollarses as required. And we will *also* send you—without charge, of course—a "must" reference work for your consultation room:

"USES OF WINE IN MEDICAL PRACTICE"

We insist you send for the 1965 edition of the latter, **free,** whether or not you are in a culinary mood. And please note, in it, the research findings on hypertension and cardiovascular condition, vis-a-vis wine. And also the data suggesting that in many regions where a high-fat diet is balanced by sufficient wine consumption, the incidence of coronary disease appears to be relatively low. We are proud of our part in many of these worldwide studies, designed to help you in your own practice. We toast you in California wine: *Good cess, good cooking, and long-lived patients to you! ¡Salud, Doctor!*

The Winemakers of California

WINE ADVISORY BOARD, DEPT. 103G, 717 MARKET STREET, SAN FRANCISCO, CALIFORNIA 94103.

Doctor's Library *(Continued)*

MEDICAL EDUCATION IN JAPAN. John Z. Bowers, M.D., 174 pages. $5.50. Harper & Row, New York, Evanston, & London.

Dr. John Z. Bowers, president of the Josiah Macey Jr. Foundation, had a long career in medical school administration. The background for this book was obtained while serving as a visiting professor at Kyoto University. Western medicine superseded the Chinese system in Japan only a century ago and the change over is rich in historical data that should be of interest to the physician and layman.

The Japanese followed the German system with emphasis on research. Most of the students prefer an academic career or an appointment as a hospital physician. The last thing they want is to practice medicine but the competition for the academic posts are so keen that the majority are forced into active practice. This is a great disappointment because of the hierarchal traditions and customs unique to Japan.

The status symbol for all physicians is a higher degree from Tokyo or Kyoto Imperial Universities. But to remain at the university they must do research. The laboratories are overcrowded with postgraduate students with little interest in learning the scientific method, experimental design, or the documentation of results.

The graduates are not attracted to the practice of medicine because the doctor-patient relationship is at a far less personalized level than in the United States. The patients are reluctant to discuss personal affairs outside the family circle. In addition, Japan has compulsory state medicine. The offices are flooded with patients and the physician has hardly the time for more than a casual greeting. Japan also is becoming less religious; 80% of the young doctors indicated to Dr. Bowers that they do not believe in a religion. This is unfortunate because it eliminates an essential characteristic of a good doctor.

Dr. Bowers also takes two medical students from college through postgraduate training. This is one of the interesting chapters of the book because it describes the attitudes, aspirations, and thinkings of the new generation. The Japanese were formerly taught ethical and moral principles in the schools as well as in the home. This system was abolished as a result of hasty modernization by American educators without full realization of Japanese practices and culture value.

T. R. Van Dellen, M.D.

DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-6952

FOR THE



COMPLEX

TRY DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

a logical first choice

FOR DEPRESSION

even when complicated by anxiety, tension, insomnia, agitation or rumination.

- Acts rapidly.
- Side effects at recommended dosage infrequent, usually easily controlled.



Dr. SIMS in ACTION

ADMINISTRATIVE AND COMMITTEE ACTIVITIES OF THE ILLINOIS STATE MEDICAL SOCIETY

March, 1966

Practical Politics for Doctors

More than 300 Illinois doctors and their wives are expected to participate in an all-day workshop on practical politics Saturday, March 26, at the Sherman House in Chicago.

According to Dr. Theodore Grevas, Rock Island, chairman of the Illinois State Medical Society's Committee on Public Affairs, which is sponsoring the event, the purpose of the workshop is to acquaint physicians with the issues and political methods of the times and to make them more "politically aware."

Highlight of the day will be an address by F. Clifton White, New York, former national director of Citizens for Goldwater-Miller and president of his own consulting firm, who will speak on "Inside Politics."

"State Issues, 1966" will be the theme of the morning program, with Sen. W. Russell Arrington (R-Evanston), President Pro Tem of the Illinois Senate; Sen. Thomas A. McGloon (D-Chicago), and Dr. V. P. Siegel, East St. Louis, chairman of the ISMS Legislative Committee, participating.

Congressman Leslie Arends, Melvin, Republican Whip in the U.S. House of Representatives, will be the featured speaker on the luncheon program.

The afternoon's agenda includes separate programs for physicians and wives.

The physicians' program, moderated by Dr. P. G. Thomsen, Dolten, chairman of the Illinois Medical Political Action Committee, includes talks on "What You Can Do in Your County Medical Society" by Dr. Grevas, and "Fund Raising, the Person-to-Person Way" by Bill Duvall, Lake Forest, director of civic affairs for Borg Warner Corp.

For the wives' program Mrs. Pat Hutar, Chicago, former assistant chairman of the Republican National Committee, and Mrs. Amos Johnson, former chairman of the Democratic executive committee of Sampson County, N. C., will team up to discuss "The Woman's Role."

The program will conclude with a late afternoon joint session on "Working with Allies," which will be presented by Roy Pfautch, St. Louis, president of Civic Service, Inc., and campaign manager for Congressman Tom Curtis. Dr. Hoy Gardner, Louisville, Ky., a member of the board of the American Medical Political Action Committee, will close the program.

Emergency Room Is Theme of Conference

"Emergency Room Service in Illinois Hospitals" is the theme of a joint conference to be sponsored by the Illinois State Medical Society and the Illinois Hospital Association Thursday, April 21, at the St. Nicholas Hotel, Springfield. To be discussed during the general session in the morning will be The Emergency Room Traffic Explosion—Causes and Implication; Quality of Emergency Care; Responsibilities of Hospitals, Physicians and Nurses (Illinois law and the Charleston case), and Patterns of Physician Coverage.

During the afternoon there will be workshops on Rotation—Making It Work; Group Contracts—the "Closed" Plan; Employed House Officers; Interns and

. . . *continued on page 284*

Special cough formula for children

Pediacof®

Each teaspoon (5 ml.) contains codeine phosphate 5 mg., Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg., chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



relieves cough
nasal drip
congestion
running nose
sneezing

eases expectoration

bright red, pleasant-tasting, raspberry-flavored syrup

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, ¼ teaspoon; from 1 to 3 years, ½ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

Winthrop Laboratories
New York, N.Y.

Winthrop

DR. SIMS IN ACTION

. . . continued from page 282

Residents and Their Graduate Education; The Nurses' Role; The Community Referral Center "Idea;" Community Education, A Public Relations Opportunity, and Emergency Room "Utilization" Use vs. Abuse.

According to Dr. Skom, the purpose of the conference is "to create special task forces to work in the problem areas most significant in the state."

Cooperating in the conference are the American Medical Association, Chicago Medical Society, Illinois Pharmaceutical Association, Illinois Department of Mental Health, Chicago Department of Mental Health, U. S.Bureau of Narcotics, Illinois Division of Narcotics Control, and the Council on the Understanding and Rehabilitation of Addicts.

Narcotics Conference Attracts Experts

A conference on the growing problem of narcotic addiction, to be sponsored by the Illinois State Medical Society March 24-25 at the Sherman House in Chicago, is attracting some of the nation's foremost experts on the subject as speakers.

Participants will include:

Leo G. Abood, Ph.D., University of Rochester Medical School, Rochester, N.Y.; David P. Ausubel, M.D., University of Illinois Bureau of Educational Research, Urbana, and Vincent P. Dole, M.D., The Rockefeller University, New York.

Also James Eckenhoff, M.D., Northwestern University's Department of Anesthesiology; Father Daniel Egan, S. A.; James H. Fox, M.D., National Institute of Mental Health, Bethesda, Md., and George H. Gaffney, Acting Commissioner of Narcotics for the U.S. Treasury Department, Washington, D. C.

Others are Jerome Joffe, M.D., Albert Einstein Medical School, New York; Thaddeus Kostrubala, M.D., Director of the Chicago Department of Mental Health; Alfred R. Lindesmith, Ph.D., Professor of Sociology at Indiana University; William R. Martin, M.D., Director of Addiction Research at the U.S. Public Health Hospital, Lexington, Ky.; Hans W. Mattick, Chicago; Karl Menninger, M.D., Topeka, Kan.; Burtis E. Montgomery, M.D., President, Illinois State Medical Society, and the Hon. James Moran, Evanston.

Also participating will be Marie E. Nyswander, M.D., New York; Herbert Raskin, M.D., Clinical Associate Professor of Psychiatry, Wayne State University, Detroit, Mich.; Morris M. Rubin, M.D., California Rehabilitation Center, Corona, Calif.; Jordan Scher, M.D., consulting psychiatrist for the Chicago Board of Health; Ross Schlich, M.D., anesthesiologist at Memorial Hospital, Springfield; the Hon. Samuel H. Shapiro, Lieutenant Governor of Illinois, and Theodore R. Sherrod, M.D., Ph.D., professor and head of the department of pharmacology at the University of Illinois.

Other speakers are Joseph H. Skom, M.D., chairman of the ISMS Committee on Narcotics; Harold Visotsky, M.D., Director of the Illinois Department of Mental Health; the Rev. R. Bruce Wheeler, chaplain for the Chicago House of Correction; O. W. Wilson, Chicago Superintendent of Police; Walter Wolman, Ph.D., Director of the AMA Department of Mental Health, and the Hon. Nicholas Zagone, Chicago.

New Volume on Cutaneous Toxicity

The effects of new chemicals on the human skin is the subject of a new volume published by the American Medical Association in cooperation with the Society of Toxicology.

"Cutaneous Toxicity" contains papers presented at a recent symposium sponsored by the two groups, and concerned with problems resulting from chemical contact with human skin.

The volume appeared in October as a supplement to Toxicology and Applied Pharmacology, official journal of the Society of Toxicology.

Copies are available at $6, paperbound or $8, clothbound, from Academic Press Inc., 111 Fifth Avenue, New York, New York 10003.

...so he might build a space ship

He's just a boy now, but he's already asking man-sized questions about the world he lives in.

"What makes the wind . . . where does the rain come from . . . why do stars shine . . . where does the night go?"



He's beginning to ask the same questions our scientists ask in exploring this and other worlds.

Right now, he's not interested in making electricity from an atom, or in testing metals or fuel for rockets; or in designing guidance and recovery systems for space capsules.

But someday he might.

And when he does, he'll have an opportunity to explore the universe right here in Illinois.

For example, it might be at the Argonne National Laboratory. This great space age facility is operated for the Atomic Energy Commission by the University of Chicago, where mankind's first controlled nuclear chain reaction was achieved. Here, scientists received training that enabled them to be the first to generate electricity from atomic energy. And it was here that the first submarine reactor was designed. Today at this great facility, more than 1,200 engineers and scientists are working toward further applications of atomic energy.

It might be in a research center at the University of Illinois in Champaign-Urbana, or in Danville where the University operates one of the nation's largest radio telescope facilities. It might be at the nation's first Bio-Medical Engineering Research Center, just recently established by Northwestern University; or at the Illinois Institute of Technology where the orbital motions of planets and satellites can be studied.

His opportunity could come at the Bell Telephone Laboratories research center soon to rise amid the cornfields near Naperville; or in one of more than 1,200 other industrial laboratories in our state. These, along with hundreds of other Illinois organizations are working toward the solution of many space age problems, right now.

If our children want to pursue the paths of basic or applied research in any field from aerospace and medicine, to electronics and nuclear physics, they'll be able to do it in Illinois.

They'll be able to because we are fortunate to have, in this state, an enlightened and progressive partnership of government, education,



business, industry, civic and religious organizations working together to provide the leadership and facilities to match our children's potential.

As a responsible member of this community partnership, we at Illinois Bell Telephone pledge ourselves to work for continued advancement of Illinois and its people. We know that only in a growing, prospering state can any private enterprise hope to grow and prosper, too.

We encourage business to build and grow in Illinois. And we invite all persons who want to live in a vital, vigorous community, to consider Illinois as a place to fulfill their hopes and ambitions.

We also invite you to send for a free booklet containing reprints of this and other similar messages, describing why we take pride in the promise of Illinois.

By sharing this information with friends, family, and business associates, both here and throughout the country, you can help others to know and understand the greatness of our state. Write to Illinois Bell Telephone, Box I, 212 W. Washington St., Chicago, Illinois 60606.

Take pride in the promise of Illinois



LOOKING FOR A PLACE TO PRACTICE?

PLACEMENT SERVICE LISTS OPENINGS

Following is a sample of the more than 150 openings for general practitioners listed with the Illinois State Medical Society's Physicians' Placement Service. Interested physicians who register with the service will be provided with a complete list of openings. Inquiries and comments should be directed to: Mrs. Robert Swanson, Secretary, Physicians' Placement Service, Illinois State Medical Society, 360 North Michigan Avenue, Chicago 60601, STate 2-1654.

Woodford County: Roanoke, population 1800. Estimated population of trade area, 4000. One physician, age 65. Second physician left after nine years to specialize, highly recommends location. Nearest hospital at Eureka, 8 miles. Nearest large city, Peoria, 25 miles. No local drug store. Fully equipped office immediately available, if desired. German predominant nationality. Sources of income: agriculture and industry. Churches: Catholic, Lutheran, Methodist, Apostolic and Bretheran. Grade and high schools. Nearest college at Eureka, 8 miles. Organizations include Business Mens Association, JayCees, KC's, PTA, etc. Nearest golf course in Eureka. 24-acre park with tennis courts, picnic area, etc. Average daily case load of physician: 30-40.

McDonough County: Bushnell, population 4,000. Estimated population of trade area, 7,000. 1 physician. 3 additional physicians in recent years. Urgent need for 1 or 2 additional physicians. Nearest hospital at Avon, 10 miles. County nursing home located here. Possibility that new county nursing home will be erected here soon. Nearest large city, Peoria, 60 miles, population, 100,000. 2 local prescription drug stores. Office space and housing available. Financial assistance could be arranged, if desired. Source of income, agriculture and industry. Churches: Catholic, Methodist, Nazarene, Church of God, Presbyterian, Baptist and Christian. Grade and high schools, nearest college, Macomb, 15 miles. Organizations include Lions, Rotary, Odd Fellows, Masons, etc. Recreational facilities include golf course, swimming pool, softball diamond, recreation center, bowling alley and park. Hygrade Packing Company will open a plant here shortly and employ approximately 200 people.

Massac County: Metropolis, population 7,500. Estimated population of trade area, 20,000. E. T. Yap, M.D. in need of an associate. Special requirements: G.P., preferably with one year of general surgery, under age 50. Minimum salary, $12,000. Percentage basis could be arranged. Opportunity for partnership after two years. Office space available. 5 additional physicians in community, ages 39-65. Massac Memorial Hospital located here, 65 beds, 1/2 mile from office. Industrial and agricultural area; 6 major industries, considerable lumbering. Protestant and Catholic churches. Grade and high schools. Paducah Junior College, 10 miles. Murray State College, 60 miles. Service clubs include Rotary, Kiwanis and Lions. Golf course nearby. Population of Paducah, 30,000. Dr. Yap is a general surgeon but does considerable general practice as well. Foreign trained physicians acceptable.

Madison County: Collinsville, population 16,000. Estimated population of trade area, 25,000. Office of Robert Kraft, M.D., 411 W. Main Street, Collinsville, who died 12/31/64, still intact, available. Dr. had practiced here for 29 years. Dr. friend and surgeon has been keeping office hours here—important that he discontinue to return to his own office full time. 12 physicians in Collinsville, including 3 specialists. "Work is underway to get a new hospital here." 10 miles from East St. Louis, population, 78,000. 8 prescription drug stores. Dr. Kraft's office equipment for sale or rent. Industrial area. 15 Protestant and Catholic churches. Grade and high schools. 12 miles from Southern Illinois University.

Kendall County: Plano, population 5000. Estimated population of trade area, 10,000. Plano Clinic in need of a second associate due to large practice. Last associate entered missionary field. Salary basis plus percentage. No investment necessary. Opportunity for partnership after six months, if desired. Equipment includes x-ray and EKG. 3 physicians in community. Nearest hospital at Sandwich, 4 miles. 64 beds, open staff. Diversified industry. 8 Protestant and Catholic churches, 4 grade and high schools. Nearest college at Aurora, 12 miles. Active Rotary and Lions Club. Active 9-hole golf course at edge of town. New shopping center. 10 miles from Montgomery industrial area.



sixty six leadership conference

Conference for county medical society presidents, presidents-elect, secretaries, executive secretaries, and public affairs and legislative chairmen.

FEATURES:

Wednesday afternoon . . . leadership panel . . . **Jim Low,** Manager, Association Department, U. S. Chamber of Commerce in **Washington, D. C.** and others . . . on leadership activities and responsibilities of county societies.

. . . The Latest Word on Medicare . . . **J. W. Cashman, M.D.,** Chief of the Division of Medical Care Administration, HEW, in **Washington, D. C.,** and leaders of the **American Medical Association** and **American Hospital Association** will offer the latest information on utilization and the physician's part in the Medicare program administration.

Thursday windup luncheon featuring **Milford O. Rouse, M.D., Texas,** Speaker of the American Medical Association House of Delegates.

Springfield, Illinois

NEW HOLIDAY INN—EAST ■ APRIL 27-28, 1966

FREE LITERATURE AVAILABLE TO MEMBERS

The various departments of the Illinois State Medical Society are offering interesting and informative literature to the membership, free of charge. Fill in the coupon below with the quantity desired on the line following the numbers.

1. Dr. Sims Guide to Voluntary Health Agencies
2. Home From the Hospital
3. Physicians' Placement Brochure
4. Students' Medical Loan Fund
5. Profile of Dr. Sims
6. Disaster Manual for Hospitals
7. Rx For a Good Meeting
8. Scientific Speakers Bureau Roster (for County Society meetings only)
9. Know Your Politics
10. How the Opinion Maker Makes Opinion
11. AMPAC's Political Education Series: "Know Your Community"; "Political Party Structure"; "The Precinct Organization"; "Working Within the Party"; "The Medical PAC Structure"; "The Candidate Support Committee"; "The Political Campaign"; and "Politics with the Woman in Mind."
12. Drug Abuse: The Empty Life
13. Prescribing and Dispensing of Narcotics Under Harrison Narcotic Law
14. Narcotics Addiction: Official Action of the American Medical Association
15. First Facts About Drugs
16. Narcotic Drug Addiction
17. Rehabilitation in Drug Addiction
18. Facts About Narcotic Drug Addiction
19. Prevention and Control of Narcotic Addiction.
20. The Official Position of the U.S. Bureau of Narcotics on Handling Narcotic Addicts
21. Interprofessional Code for Physicians and Lawyers of Illinois

1.———	8.———	15.———
2.———	9.———	16.———
3.———	10.———	17.———
4.———	11.———	18.———
5.———	12.———	19.———
6.———	13.———	20.———
7.———	14.———	21.———

Mail to:
Illinois Medical Journal
360 North Michigan Avenue
Chicago, Illinois 60601

NAME _____

ADDRESS _____

CITY_____ STATE_____ ZONE_____

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

DRUG ADDICTION STUDIED BY MEDICAL ASSISTANTS

Narcotics and addiction is a subject that is being studied by medical assistants all over Illinois this year. In October the Kane County Medical Assistants heard Mr. Joseph Fiedoral speak on this subject. He has been a Chicago police officer for 27 years, where he gained first hand knowledge and experience of the narcotics problem and the recognition of its deadly menace. In December, the Central Branch of the Cook County Medical Assistants Association heard Lt. Cornelius Casey from the Narcotics Squad of the Chicago Police Department speak on "The Problem of Narcotics." And in February the Du Page County Medical Assistants heard Mr. Lawrence Slotnik, of the U.S. Treasury Dept., Bureau of Narcotics, who is also a registered pharmacist.

Narcotic drugs are defined as any that are derived from the opium poppy or any synthetic drug declared to be a narcotic by presidential proclamation. Those proclaimed to be narcotics exhibit the same characteristics as natural narcotics. The three most common natural narcotics are morphine, codeine, and papaverine. Heroin is a derivative of morphine. The synthetics include demerol and dolephine. All are considered addicting.

All addicting drugs have three characteristics in common. They are:

1. Tolerance
2. Physical Dependance
3. Psychological Dependance

Tolerance means that the body builds up an immunity to the drug, which requires that one take increasingly larger amounts to obtain the same effect. Physical dependence involves requiring regularly administered amounts of the drug or violent illness ensues. The classical sympthoms are tearing, running nose, stomach cramps and crawling on the floor and shrieking for a period of 72 hours. Psychological dependence involves the mental habituation to the drug. The people who become addicted to narcotics were mentally ill before they became users, therefore they do not have the capacity to throw off the habit.

All narcotics, with the exception of cocaine, are depressant drugs. They depress *all* bodily functions. Cocaine is a stimulant. A slight overdose of cocaine will make the patient talkative.

Marihuana is a weed that grows in many areas of the world. The leaves and flowering tops are crushed and rolled into a cigarette. It is a depressant, but is not addicting. It has two important characteristics:

1. Its reaction on any individual cannot be predicted.
2. The user will eventually certainly graduate to addicting narcotics.

Narcotic addiction is a problem of metropolitan areas. The Federal Bureau of Narcotics states that there are 60,000 known addicts in the U.S. New York leads the nation with 48.3% of the country's addicts. Illinois ranks second with 14.6%, closely followed by California with 14.0%. The rest of the nation covers the remaining 23%. The only state with no addiction is Alaska.

There are two schools of thought on how to control the addiction problem. One is the establishment of clinics for legal and

continuing dispensing of narcotics to addicts. This idea has met with opposition on several counts.

1. Because addiction involves tolerance, the clinic plan would supply the addict with a basic supply and he then would still patronize the "pusher" to supply his increasing demands.
2. Countries that have tried this plan have found it is not successful.
3. It would clash head-on with our country's agreements with the nations of the world.
4. The proposed clinics would contradict the nation's internal policies.

The second proposal is compulsory hospitalization of narcotics addicts, where they would have no access to narcotics from any source. Since the addict is lacking is self-control, he needs to be confined and treated, and then given adequate after-care to prevent a relapse. This opens the doors to the possibility of cure. While the cure rate in Lexington, Ky. is only 2%, this is under circumstances that the addict voluntarily admits himself and can walk out at any point during the treatment that he chooses. Experience in other nations indicates that only when the addict can be treated in closed institutions for prolonged periods of time can treatment be effective.

Tenth Annual IMAA Convention

Don't forget to allow time for your medical assistant to attend the IMAA Convention in Bloomington on April 23, 24, and 25. The theme of the convention is "The Forward Look" where speakers will cover such subjects as "The Tension State," "Medicare Procedure," "Barbiturates and Amphetamines" and "Foods Out of This World" to mention a few.

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed double space and submitted in duplicate, one original and one carbon. An article should not exceed 12 to 16 pages, briefer if possible.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month, if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to: T. R. Van Dellen, M.D., Editor, Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601.

NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen*

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

New Single Chemicals—Drugs not previously known, including new salts.
Duplicate Single Products—Drugs marketed by more than one manufacturer.
Combination Products—Consisting of two or more active ingredients.

NEW SINGLE CHEMICALS

THIOGUANINE: Cancer Chemotherapy ℞
Manufacturer: Burroughs Wellcome & Co. (U.S.A.) Inc.
Nonproprietary Name: Thioguanine
A close relative of mercaptopurine. An antimetabolite which blocks purine metabolism.
Indications: Treatment of acute leukemia and chronic granulocytic leukemia.
Dosage: Usual initial dose is approximately 2 mg./kg. body weight/day orally. May be cautiously increased to 3 mg./kg./day. Total daily dose may be given at one time, and it is usually calculated to the closest multiple of 20 mg.
Supplied as: Tablets 40 mg. Bottles of 25.

DUPLICATE SINGLE PRODUCTS

CORTENEMA: Hormones-Corticoids ℞
Retention Enema
Manufacturer: Rowell Laboratories Inc.
Composition: 60 cc. unit: Hydrocortisone alcohol 100 mg. in aqueous, isotonic saline containing methylcellulose as a suspending agent and emollient; polysorbate 80, and 0.18% methylparaben and 0.02% propylparaben, as preservatives.
A suspension of partially solubilized hydrocortisone alcohol, with a new therapeutic approach.

Indications: As an adjunct in the treatment of idiopathic nonspecific ulcerative colitis.
Topical Effect: Most useful in cases involving the rectum, signoid and left colon.
Systemic Action: In certain cases extending to the transverse and ascending colon.

Dosage: One (1) unit daily for two or three weeks and every second day thereafter. Administered intrarectally in the evening before retiring.

Supplied as: Disposable, single-dose unit consisting of a flexible plastic container with a lubricated applicator tip.
In boxes of 7 single-dose units.

NEW COMBINATION PRODUCTS

ACCELERASE: Enzymes Digestive o-t-c
Manufacturer: Organon, Inc.
Composition: Capsules:
Pancrelipase Approx. 165 mg.
Lipase 1,000 Organon u.
Amylase, equiv. to a minimum of 750 mg. Pancreatin N.F.
Trypsin, equiv. to a minimum of 600 mg. Pancreatin N.F.
Other pancreatic enzymes derived from hog pancreas.
Mixed conjugated bile salts.....65 mg.
Cellulase 2 mg.
Calcium Carbonate 20 mg.
Combines digestive activity of concentrated pancreatic enzymes with bile salts and cellulase.
Indications: Functional digestive disorders arising from temporarily impaired secretory activity of the digestive tract.
Dosage: One to two capsules with each meal.
Supplied as: Capsules. Bottles of 60.

. . . continued on page 292

**This is the first in the series of reviews of New Pharmaceutical Specialties by Mr. Paul deHaen, consultant to the pharmaceutical industry, author and publisher. His reviews will appear as a regular monthly feature in the Journal.*

NEW PHARMACEUTICAL SPECIALTIES . . . *continued*

NEW COMBINATION PRODUCTS

ACCELERASE-PB: Enzymes Digestive ℞

Manufacturer: Organon, Inc.

Composition: Capsules:

Pancrelipase Approx. 165 mg.
Lipase 1,000 Organon u.
Amylase, equiv. to a minimum of 750 mg. Pancreatin N.F.
Trypsin, equiv. to a minimum of 600 mg. Pancreatin N.F.
Other pancreatic enzymes derived from hog pancreas.
Mixed conjugated bile salts.....65 mg.
Cellulase 2 mg.
Calcium Carbonate 20 mg.
Belladonna alkaloids (levorotatory) 87.5% hyoscyamine and 12.5% atropine as sulfate 0.2 mg.
Phenobarbital 16 mg.
Combines digestive activity of concentrated pancreatic enzymes with bile salts, cellulose, belladonna alkaloids and phenobarbital.

Indications: Symptomatic therapy for the multifaceted problems of certain functional disorders of the upper digestive tract, as well as related upper abdominal distress arising from emotionally triggered impairment of secretory or motor digestive activity.

Dosage: One (1) capsule three times a day with meals.

Supplied as: Gray and white capsules. Bottles of 60.

K-LYTE: Potassium Supplement ℞

Manufacturer: Mead Johnson & Co.

Composition: Effervescent Tablet: supplies:
Potassium Bicarbonate 2.5 Gm. (25 mEq. elemental potassium)
Citric Acid 2.1 Gm.
With cyclamic acid, artificial flavor and color.
In water becomes potassium citrate, potassium bicarbonate and potassium cyclamate.

Indications: For therapy or prophylaxis of potassium deficiency.

Dosage: Adults: 1 tablet dissolved in 3 to 4 ounces of water two to four times daily, depending on the requirements of the patient. Two tablets (50 mEq. of potassium) supply the approximate daily requirement for the normal adult.

Supplied as: Effervescent tablets—box of 30, each tablet individually foil wrapped.

METHALOID: Antiobesity Preparation ℞

Manufacturer: S. J. Tutag & Company

Composition: Granutab:
Methamphetamine HCl 10 mg.
Amobarbital 60 mg.
Tuloidin (defatted pork thyroid)....150 mg.
Appetite depressant combined with a sedative and thyroid.

Indication: Appetite depressant.

Dosage: One (1) Granutab preferably in the morning, with or immediately after breakfast.

Supplied as: Granutab (sustained release tablet). Bottles of 100.

R V PAQUE: Dermatologic Preparation o-t-c Light occlusion

Manufacturer: Paul B. Elder Co.

Composition: Red Petrolatum (RVP)
Zinc Oxide
2-ethoxyethyl p-methoxycinnamate.
In a greaseless, water resistant base (Eldogel).
A hydrophobic ointment which acts as a total light block and allows no tanning rays to pass.

Indications: Light occlusion (sun screen).

Dosage: Apply in a uniformly thin film to area involved.

Supplied as: One-half ounce tubes.

XYNISONE: Hormones-Corticoids ℞

Manufacturer: B. F. Ascher & Co., Inc.

Composition: Prednisone 5 mg.
Dihydroxyaluminum Aminoacetate..300 mg.
Buffered prednisone to prevent disagreeable side effects of steroid therapy.

Indication: Wide range of conditions for which prednisone's antiinflamatory effect is desired.

Dosage: One to four tablets four times daily for 3 to 7 days, then gradually reduced to 1 to 4 tablets daily.

Supplied as: Tablets. Bottles of 100 and 500.

HYDROMOX R: Antihypertensive ℞

Manufacturer: Lederle Laboratories Division American Cyanamid Company

Composition: Quinethazone 50 mg.
Reserpine 0.125 mg.
Combines non-mercurial diuretic and reserpine.

Indications: Mild to moderate hypertension, with or without edema.

Dosage: One to two tablets, once daily.

Supplied as: Tablets. Bottles of 100 and 500.

Rx Reviews

and New Products

Improved Catheter From B. F. Goodrich

An improved inflatable retention catheter that reduces urethral irritation and provides a higher flow rate has been introduced by B. F. Goodrich, called Korocath, after the material from which it is made.

"Extensive medical tests have shown that the Korocath catheter is designed and engineered for ease of insertion and reduction of discomfort to the patient," said Rex H. Wilson, M.D., the company's medical director. "The material is a special formulation of high quality vinyl, developed for hospital procedure. At normal temperature it maintains the proper rigidity for easy insertion without the use of a stylet. Once inside the body, the material softens and follows the internal contours, thus reducing patient discomfort."

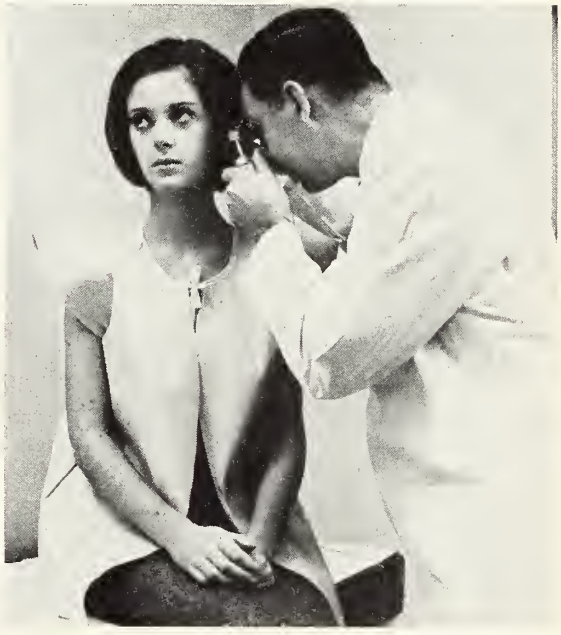
Tests indicate that the new product offers other advantages to both the urologist and patient, Dr. Wilson said.

"Three years of clinical studies show that the new catheter is superior to conventional models in reduction of hyperemia, edema and encrustation. And because of its new thin-wall design, the Korocath catheter produces a flow rate that is higher than ordinary catheters with the same outside diameter."

The new catheter is irradiation sterilized, color-coded for identification, and packaged in an easy-peel transparent package. It is available through distributors of the company's hospital and surgical supplies.

For further information contact: B. F. Goodrich Consumer Products Marketing Division, 277 Park Avenue, New York, N.Y. 10017.

Scott Introduces Disposable Jackets



Jackets, capes and waterproof aprons made of tear-resistant, rayon-reinforced paper have been developed by Scott Paper Company for medical examinations and laboratory use.

The new products are freshly packaged and readily disposable, thus eliminating laundry expenses.

Jackets and capes are especially suited for wear by female patients. Both offer protection from neck to waist and allow the patient to remain partially dressed during the examination. The jacket has roomy sleeve openings, a cloth neck binding and can be fastened securely at the middle with cloth ties. Capes drape around the shoulders and also fasten with cloth ties.

. . . continued

. . . *continued*

In both jackets and capes, the opaque quality of the specially processed paper eliminates see-through and a rayon scrim, sandwiched between highly absorbent paper plies, reinforces the construction.

Aprons are laminated to polyethylene to form a waterproof coating to protect the wearer's clothing or uniform from fluids, medicines, chemicals or specimens.

Further information is available from the Professional Services Department, Dura-Weve Division IM-115, Scott Paper Company, Philadelphia, Pa. 19113.

New Method for Diagnosing Intra-Uterine Cancer

A new method for the diagnosis of intra-uterine cancer has been developed by George Wied, M.D., at the University of Chicago Medical Center.

Dr. Wied is an associate professor of obstetrics and gynecology in the Division of Biological Sciences at the University. He is also Director of the Eugene F. McDonald, Jr., Laboratory for Exfoliative Cutology at the University medical center.

"We have been testing this fluorometic method for the diagnosis of intra-uterine cancer for the past six months," Dr. Wied says. "Our experience indicates that it could be used routinely as part of regular gynecological checkups for all women past the age of 40 just as the 'Pap' smear for cervical cancer has become routine."

The fluorometric test, a painless procedure which does not require hospitalization or anesthesia, is done on a sample of cells easily removed by the physician from the cavity of the uterus. A very narrow, sterile tube is inserted through the cervical canal into the cavity of the uterus. The tube contains a tiny brush which is then pushed out so that it extends beyond the top of the tube into the cavity.

This cavity contains a thick mucus in which is suspended the cells which have been shed from the glandular lining of the walls of the uterus. The mucus adheres to the brush so that it becomes coated with a very good random sample of the entire cell population of the uterus.

For diagnostic purposes this type of cell sample seems much more likely to show the presence of any abnormal cells than a "punch biopsy," since the instrument which punches out the cell sample may miss a tumor area completely and provide only normal cells for diagnostic examination.

Dr. Wied uses for this evaluation a fluorospectrophotometer which measures the amount of fluorescence emitted by the cells. The amount of fluorescence is directly related to the quantity of nucleic acids present within the nucleus of each cell. All rapidly growing cells, such as those found in the uterus of a woman prior to menopause, contain more nucleic acids than the non-functioning cells obtained from a woman who is past the child-bearing age. Cancer cells contain more nucleic acids than either of these types of cells and substantially more nucleic acids than the non-functioning cell.

In order to demonstrate this quantitative difference, the nucleic acids of the cell nuclei are stained with a fluorescent dye. It is the measurement of the fluorescent complex of this dye plus nucleic acids which allows for the accurate determination of the nucleic acids content of individual cells. Thus, by the use of this method, Dr. Wied is able to measure a much larger emission of fluorescent light from cancer cells than from the normal non-functioning type of cell found in the uterus of the post-menopausal woman.



Dr. Davidsohn Honored On 35th Anniversary

On the occasion of the completion of Dr. Israel Davidsohn's thirty-five years as director of the department of pathology and his appointment as director of the department of experimental pathology at the Mount Sinai Hospital Medical Center, a banquet was given in his honor by the Medical Center's Board of Directors.

"Dr. Israel Davidsohn, director of the department of experimental pathology at the Mount Sinai Hospital Medical Center, is recognized internationally as one of the outstanding physicians of his generation." This was the tribute paid to Dr. Davidsohn by Dr. Alan R. Moritz, Provost of Western Reserve University, one of the speakers at the banquet.

"This distinction," said Dr. Moritz, "is based on Dr. Davidsohn's many contributions as teacher, investigator and practitioner in the diagnosis and control of treatment of disease through the utilization of the precise techniques of the laboratory."

Another tribute, an unusual honor for a living man, was paid Dr. Davidsohn by the Mount Sinai Board of Directors when Solomon Katz, president of the board, announced they had voted to name the department of pathology at the hospital the Dr. Israel Davidsohn Department of Pathology.

In making this announcement, Mr. Katz stated: "When Dr. Davidsohn became director of the department of pathology in 1930, it was practically a one-man operation. Under Dr. Davidsohn's direction the department grew until today it performs well over half a million diagnositic tests a year, employs over 120 medical, scientific and associated personnel, has subdivisions in the specialties of microbiology, parasitology, immunohematology, microchemistry, virology and serology and conducts research on cancer, leukemia, hemolytic anemia, Rh problems and many more. The blood center, one of 23 reference laboratories in the country, came into being as a result of Dr. Davidsohn's lifelong interest in blood groups and diseases of the blood and his work on the Rh factor."

A scroll commemorating the renaming of the department of pathology was presented to Dr. Davidsohn, in behalf of the board of directors, by Mr. Katz.

Mount Sinai Installs New Freezer for Blood

A thousand pound, twenty-five cubic foot freezer capable of extending the life span of a unit of human blood from the present 21 days to at least five years was installed at the Charles Hymen Blood Center at the Mount Sinai Hospital Medical Center recently.

Built by the Linde Division of the Union Carbide Corporation, the freezer is the only one of its kind in existence.

Freezers of the mechanical variety, similar to household deep freezers, have been used in various parts of the country for the storage of blood. The Linde Freezer is unique, however, in that it employs liquid nitrogen as a coolant and has no mechanical parts.

After a unit of donated blood is thoroughly checked to insure that it is safe for transfusion it is put into a centrifuge and an anti-freeze solution (in this case, glycerol) is then added to the blood cells which are then frozen.

When a unit of blood is needed for transfusion, the glycerol is removed by a cytoglomerator.

The whole process takes only fifteen minutes. Ninety-five percent of the red cells will survive in the patients, as is the case in directly transfused blood.

Although still experimental, the new freezer is believed to have advantages over conventional models. First, it has the advantage of eliminating the worry over possible mechanical failures. Secondly, in comparison to the size of conventional freezers,

it permits more units of blood to be stored. It is also believed that nitrogen vapor cooling will allow for more accurate control over the temperature range in the freezer.

The new freezer is designed to hold blood at temperatures ranging from minus 112 degrees fahrenheit to minus 148 degrees fahrenheit. The standard household freezer maintains a temperature of 14 to 24 degrees fahrenheit. The lower temperature range provided by the Linde unit will allow for a quick freezing of blood and will minimize the problem of ice crystals forming when the blood is frozen.

It is expected that the new equipment will open up new areas of investigation such as the effects of freezing and thawing on blood cells, including comparison of variations in technique. An overall evaluation of the effectiveness and safety of the final transfusion will also be investigated.

Illinois Public Aid Dept. Assumes Medicare Responsibilities

Dr. Franklin D. Yoder, State Public Health Director, has received the official agreement between the U.S. Department of Health, Education and Welfare and the Illinois Department of Public Aid authorizing the department to assume its responsibilities under the provisions of the recent Social Security Amendments, commonly referred to as "Medicare."

The department's first function under the agreement is to certify eligible hospitals and home health agencies by July 1, 1966. Eligible skilled nursing homes must be certified by January 1, 1967.

The second function involves special consultative services to assist the institutions and agencies in achieving certification and maintaining the necessary standards of medical care.

The third function involves coordination of the Medicare program and other available health services on state and local levels.

The federal government will recompense the State of Illinois for the proportionate cost incurred in operating the program. As a result of the agreement, the Illinois Public Health Department is recruiting additional staff to carry out its initial responsibilities. The staff will contact hospitals, nursing homes, home health agencies and heads of other qualified services to explain how they may participate in Medicare.

Announce 1966 Rorer Awards Contest

The American College of Gastroenterology, in cooperation with William H. Rorer, Inc., of Fort Washington, Pa., has announced the 1966 Rorer Awards Contest for the best papers in gastroenterology.

There will be two classes of awards as follows:

1. "For the best unpublished papers in gastroenterology or an allied subject." This category is open to interns, residents or fellows and the first prize is $500 and a 3-year subscription to the "American Journal of Gastroenterology"; second prize, $300 and a 2-year subscription; and third prize, $200 and a 1-year subscription.

2. "For the best paper published in the American Journal of Gastroenterology." These prizes are to be awarded for the best papers published during the 12 months ending June 30, 1966 and are identical to those awarded for the first category.

All papers submitted must represent original work in gastroenterology or an allied subject and must not have been previously presented at meetings of any national society.

The contents of the papers may be clinical or basic science. Clinical papers must not be case records but controlled clinical work.

All entries must be typewritten in English, double-spaced on one side of the paper and submitted in six copies. The length of the paper is no criterion for originality or value.

All entries must be received no later than May 15, 1966 and should be addressed to the Research and Scientific Investigation Committee, American College of Gastroenterology, 33 West 60th Street, New York, New York 10023.

NEW REGULATIONS OVER DEPRESSANT AND STIMULANT DRUGS

Physicians are reminded that on February 1 of this year new regulations went into effect to provide federal controls over depressant and stimulant drugs. Public Law 98-74 and its amendments cover the manufacture (including preparation, propagation, compounding, and processing), distribution (including jobbing, selling and wholesaling), delivery and possession of barbituates, amphetamines and other drugs which have a potential for abuse because of their depressant or stimulant effect on the central nervous system or because of their hallucinogenic effect.

Of special interest to the physician are the record-keeping requirements which call for a complete history of the drug beginning with its manufacture and ending with its disposition. This includes records of professional samples of those drugs obtained from medical representatives.

Physicians who are regularly engaged in dispensing stimulant and depressant drugs to their patients and who make a charge for the drugs, "either separately or together with charges for other professional services," must keep records of receipt and disposition and make them available for inspection, although they are not required to register with the U.S. Department of Health, Education and Welfare unless they wholesale these drugs to others.

The maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations (for example, as a stopgap measure to tide patients over until a regular supply of drugs can be obtained by prescription from a pharmacy, or dispensing as trial doses to patients), will not be considered as regularly engaged in dispensing for a fee, and consequently no special record keeping is necessary.

Prescriptions for depressant and stimulant drugs may be given by oral or telephone order according to the usual practice. However, no prescription order can be renewed more than five times and no prescription order can be dispensed or renewed more than six months after date of issue.

The Food and Drug Administration has defined the term "depressant or stimulant drug" as any which contains any quantity of:

1. Barbituric acid or any of the salts of barbituric acid.

2. Any derivative of barbituric acid which has been designated by the Commissioner under Section 502(d) of the act as habit-forming.

3. Amphetamine or any of its optical isomers.

4. Any salt of amphetamine or any salt of an optical isomer or amphetamine.

Any substance which the Commissioner, after investigation, has found to be, and by regulation designated as, habit-forming because of its stimulant effect on the central nervous system.

6. Any substance which the Commissioner, after investigation, has found to have, and by regulation designates as having, a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic effect.

Following is a partial list of amphetamine products listed in FDA regulations, with some trade or other names following each product in parenthesis:

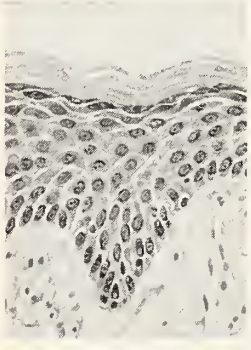
Amphetamine phosphate (Actemin, Aktedron, Amphate, Biphetamine, Dictamine, Monophos, Profetamine Phosphate, Racephen, Raphetamine Phosphate).

Amphetamine salts or optical isomers of amphetamine salts.

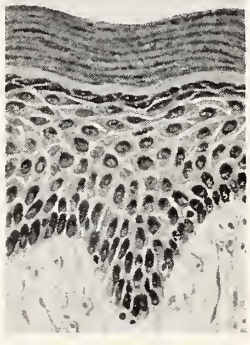
Amphetamine sulfate (Alentol, Amphoids-S, Benzedrine Sulfate, Linampheta, Psychoton, Simpamina, Amphedrine Sulfate).

new!

ORAL
Photoprotective Agent
Trisoralen® Tablets
TRIOXSALEN—ELDER



BEFORE—Normal epidermis before Trisoralen therapy



AFTER—Epidermis following Trisoralen therapy

- Provides added epidermal dimensions of protection for light sensitive skin. Enhances pigmentation in vitiligo.
- Develops compact adherent melanin-saturated stratum corneum.
- Thickens stratum corneum, stratum lucidum,[1-3] and Malpighian layers.
- Increases melanin concentration with retention in epidermal layers.
- Six times the LD_{50} of methoxsalen—only half the dosage of methoxsalen, due to 2X activity.
- No liver function test required.

CONTRAINDICATIONS: Diseases associated with photosensitivity, such as porphyria, acute lupus erythematosus, or leukoderma of infectious origin.

To date, the safety of this drug in young persons (12 and under), has not been established and is, therefore, contraindicated.

DOSAGE: Adults and children over 12 years: two tablets daily as directed in brochure.

SUPPLIED: Bottles of 28 and 100 coated tablets. *Also available:* Oxsoralen Lotion when the natural botanical is preferred.

References: (1) Becker, Jr., S. W.: J.A.M.A. 173: 1483-1485, 1960; (2) Pathak, M. A., and Fitzpatrick, T. B.: J. Investig. Dermat. 32:509-518, 1959; (3) Pathak, M. A., Fellman, J. H., and Kaufman, K. D.: 33:165-183, 1960.

Write for literature and clinical supply of Trisoralen
PAUL B. ELDER COMPANY • Bryan, Ohio.

Dextroamphetamine carboxymethylcellulose salt.

Dextroamphetamine hydrochloride.

Dextroamphetamine phosphate (Dextro-Profetamine).

Dextroamphetamine sulfate (Adrizine, Am-Dex, D-Amfetasul, Amitremne, Amphedrine, Ampherex, Amphex, Amsustain, D-Ate Ph. 747, Betafedrina, d-Betaphedrine, Cendex Cenules, D-Citramine, Cradex, Dadex, D.A.S., Dexalone, Dexamphetamine, Dexedrine, Dex-OB, Dex-Sule, Dexten, Dextrosule, Diocurb, Domafate, Evrodex, Hetamine, Lowedex, Maxiton, Medex, Nilox, Obesedrin, Obesonil, Pelicape, Pomadex, Simpamina-D, Sympamin, Tydex, Zamitam Plateau.

Dextroamphetamine sulfate (Tanphetamin, Synatan)

Dibasic amphetimine phosphate (Bar-Dex)

Dibasic dextramphetamine phosphate

Lovoamphetamine (Ad-Nil, Amphedrine-M, Lavabo, Lavamphetamine, Levonor)

Levoamphetamine succinate (Cydril)

Penalty for violation of the law and its amendments is imprisonment for not more than two years, or a fine of not more than $5,000, or both such provisions for second and subsequent violations.

AMA Environmental Health Congress Will Consider 'Accident Epidemic'

Has man designed accidents into his environment? If so, what can he do about it?

These and other questions will be discussed at the American Medical Association's Third Congress on Environmental Health Problems April 4-5 at the Drake Hotel, Chicago.

In announcing the Congress, James G. Telfer, M.D., director of the AMA's Department of Environmental Health, said participants "will be concerned with accidents and their relationship to environmental design — from the automobile, to the home and work environment, to the overall urban plan—and with the medical problems of treatment, prevention and mitigation, and research."

Based on the theme, "Accidents — A Preventable Epidemic," the Congress will include four panel workshops.

New Blood Study Under Way at U. of I. College of Medicine

A two-pronged research project, aimed at identifying the plasma protein antigens which differ from one individual to another and then attempting to determine how and why maternal antibodies to them may cause long-range difficulties in developing offspring, is currently being conducted by the University of Illinois College of Medicine.

Principal investigator is Dr. Sheldon Dray, head of the Department of Microbiology at the College. To enable him to carry on the research, entitled "Genetic, Chemical and Immunological Studies of Serum Protein Allotypes," Dr. Dray has been awarded a $120,000 grant by the National Science Foundation, Washington, D.C.

Dr. Dray's study is based on discoveries within the past few years that, similar to red blood cells, proteins in blood differ among individuals in their antigenic characteristics and, consequently, plasma transfused from one individual to another may lead to production of antibodies.

Such antibody protection, he says, might help explain some of the transfusion reactions of unknown cause which, while seldom fatal, can cause difficulties ranging from problems which crop up during pregnancy to diseases of the newborn.

Basically, according to Dr. Dray, these differences in plasma proteins between the male and female test animals used (mostly mice and rabbits) show that, as a result of a transfusion reaction, the blood of the offspring can be found to contain an almost total absence of proteins normally found in male blood. This is but one result and the clinical significance is being evaluated.

In general, it is Dr. Dray's opinion that, just as the discovery of blood groups led to the identification of many genes in man, identification of protein groups will also lead to the discovery of many new genes. As the genetic constitution of individuals is more completely established, he concludes, medical science will find it easier and safer to transplant organs and tissue which, to really succeed, requires matching the critical genes of donor and recipient.

Forest Hospital

is an intensive care facility noted for its advanced, comprehensive treatment programs. One such program is the adolescent service, which provides psychotherapy for girls and boys from 13 through 17. Accredited school facilities are on campus. Parents of children in treatment receive therapy and social work follow up. A game room, swimming pool, recreational activities are offered in a total setting designed to speed recovery. A psychiatrist specializing in adolescence is in charge.

555 Wilson Lane
Des Plaines, Illinois
Dial 827-8811

Adolescent Program,
Dr. Daniel Schiff, Director

This is one in a series of advertisements describing some of the services offered at the hospital.

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
Starting Dates — 1966

SPECIALTY REVIEW COURSE IN OB-GYN, Two Weeks, March 21
SPECIALTY REVIEW COURSE IN ORTHOPEDICS, April 18
SPECIALTY REVIEW COURSE IN PEDIATRICS, April 18
SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 16
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
ESSENTIALS OF PLASTIC SURGERY, One Week, March 28
GENERAL SURGERY, One or Two Weeks, March 21, April 18
FLUIDS & ELECTROLYTES, One Week, March 28
THORACIC SURGERY, One Week, March 28
BLOOD VESSEL SURGERY, One Week, May 9
SURGERY OF HAND, One Week, May 9
VAGINAL SURGERY, One Week, May 9
OBSTETRICS, General & Surgical, Two Weeks, April 18
PAIN RELIEF IN CHILDBIRTH, Three Days, April 13
BASIC INTERNAL MEDICINE, One Week, April 25
CLINICAL USES OF RADIOISOTOPES, Two Weeks, April 25
DERMATOLOGY, One Week, April 25
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

TEACHING FACULTY
Attending Staff of
Cook County Hospital
Address: REGISTRAR, 707 South Wood Street
Chicago, Illinois 60612

"ALCOHOLISM is a DISEASE"

The Keeley Institute, Dwight, Illinois, specializes in the individual and group care of those having a drinking problem.

Our progressive, well-rounded program is conducted in an atmosphere of friendly cooperation under the direction of physicians and experienced personnel. We take female patients as well as male.

The alcoholic can be helped . . .

Why not write now for detailed information on our low cost, comprehensive services — or phone 815 584-3001.

The Keeley Institute is a member of the American Hospital Association — Licensed by the Dept. of Public Health, State of Illinois.

Chicago Medical School Expands Psychiatric Program for Physicians

Expansion of the Chicago Medical School program in psychiatry to give extensive new emphasis to the field has been announced by Dr. John J. Sheinin, president of the school.

In describing the enlarged program, Dr. H. H. Garner, chairman of the department, said:

"There is an increasing awareness that the ability of the physician—whatever his specialty—to deal to some extent with emotional problems of his patients may constitute the difference between successful and unsuccessful treatment of a sick patient."

A principal feature of the program is a mandatory new first-year course in human development, presented in cooperation with the department of pediatrics. The course is taught by both the Chicago Medical School faculty and visiting authorities, including geneticists, anthropologists and sociologists as well as psychiatrists, psychologists and pediatricians.

The second-year course covers the disease patterns—the neuroses and psychoses.

For the third year, there will be a required eight-week clerkship in psychiatry at one of the school's affiliated institutions. Plans for the fourth year include a 12-week clerkship.

Another aspect of the school's program in psychiatry is the training of residents in psychiatry at hospitals and clinics associated with the school.

Hospitalization For Emotionally Disturbed Patients

- MERCY HOSPITAL, Urbana, Ill., a not-for-profit general hospital, offers a Completely Modern, 30-bed Psychiatric Unit.
- The Unit is an evaluation & intensive treatment center, not intended for the care of the incurably mentally ill.
- It is equipped to offer more Intensive Care at Less Expense, Quickly Available Care, a Consultative Staff in Many Specialties, and has three Board-Qualified Psychiatrists on the Staff.
- All Physicians, staff and non-staff are invited to make psychiatric referrals.

For information concerning admission:

PSYCHIATRIC UNIT—MERCY HOSPITAL
1412 West Park Street, Urbana, Illinois
Area Code 217—Ph. 367-6621 Ex. 513

North Shore Hospital

On its doorstep, the restful vista of Lake Michigan

Care and Treatment of Emotional Disorders

NSH

Fully Accredited

225 Sheridan Rd. WINNETKA, ILLINOIS Hillcrest 6-0211

for information contact: Milton A. Dushkin, M.D.
MEDICAL DIRECTOR

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO OFFICE: Tam J. Hoehn and E. M. Breier, Representatives
55 East Washington Street, Raam 1334, Chicago 60602 Telephone: 312-782-0990
MOUNT PROSPECT OFFICE: Theadare J. Pandak, Representative
709 Hackberry Lane (P. O. Bax 105) Maunt Praspect 60056 Telephane: 312-259-2774
ST. CHARLES OFFICE: Joseph C. Kunches, Representative
1220 Wing Avenue, St. Charles 60174 Telephane: 312-584-0920
SPRINGFIELD OFFICE: William J. Nattermann, Representative
1124 Sauth Fifth Street, Springfield 62703 Telephane: 217-544-225

OBITUARIES

Glen Agamy, Wilmington, died January 4, aged 49. A graduate of Rush Medical College in 1938, he specialized in internal medicine.

Martin W. Caveney*, Park Ridge, died January 24, aged 79. In 1915 he graduated from Northwestern University Medical School and specialized in otolaryngology. He was a member of the Fifty Year Club of ISMS.

Carl L. Cohen*, Chicago, died January 23, aged 69. He was a graduate of Chicago College of Medicine and Surgery in 1920 and specialized in pediatrics. He retired in 1963.

Ray W. Doud*, Normal, died January 16, aged 66. He was a graduate of Northwestern University Medical School in 1926.

Ilia M. Finesilver, Chicago, died January 17, aged 68. A graduate of Chicago Medical School in 1931, he was on the staff of Louise Berg nospital.

Clarence A. Fleischli*, Springfield, died January 29, aged 55. He graduated from Northwestern University Medical School in 1939. An ophthalmologist, he specialized in the diseases and surgery of the eye. He was a member of the Illinois Ophthalmologist Society.

Esther T. Frankel, Chicago, died November 10, aged 77. She was a graduate of Albertus-Universitat Medizinische Fakultat, Konigsberg, Prussia in 1913.

Harry M. Hedge*, Evanston, died January 23, aged 81. A graduate of Northwestern University Medical School in 1917, he specialized in dermatology. President of ISMS in 1950, he retired in 1963. He was an emeritus member of ISMS.

Ludwig Korkes*, Chicago, died December 21, aged 71. He was a graduate of Medizinische Fakultat der Universitat Wien, Vienna, in 1921.

Rudolph S. Lackenbacher*, Chicago, died January 16, aged 70. A graduate of Medizinische Fakultat der Universitat Wien, Vienna, in 1920, he specialized in dermatology. He was on the staff of Columbus and Frank Cuneo Memorial hospitals.

Everett L. Lanman*, Belleville, died January 8, aged 67. A graduate of Indiana University School of Medicine in 1923, he specialized in radiology and roentgenology. He was an honorary staff member of St. Elizabeth's hospital.

Albert L. Liederman*, Rock Falls, died August 2, aged 55. He was a graduate of Chicago Medical School in 1938.

John A. Melyn, Chicago, died February 4, aged 60. He was a graduate of McGill University Faculty of Medicine, Montreal, 1933.

Howard A. Orvis, Winnetka, died January 15, aged 80. He was a graduate of State University of New York at Buffalo, School of Medicine in 1910. He retired in 1952.

James K. Rosson*, Tamms, died February 4, aged 71. He was a graduate of the National University of Arts & Sciences Medical Department, St. Louis, in 1915. He was also a member of the Fifty Year Club of ISMS.

Ferdinand Seidler*, Chicago, died February 2, aged 77. A graduate of Medizenische Fakultat der Universitat Graz, Graz, Austria, in 1914, he specialized in orthopedic surgery. He was attending orthopedic surgeon at both Children's Memorial and Grant hospital. He was a member of the American Board of Orthopedic Surgeons and the American Academy of Orthopedic Surgeons as well as many other medical societies. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Milton L. Smith, McHenry, died January 19, aged 78. He was a graduate of Chicago Medical School in 1916.

William Somerville*, Chicago, died January 18, aged 69. He was a graduate of Loyola University School of Medicine in 1927.

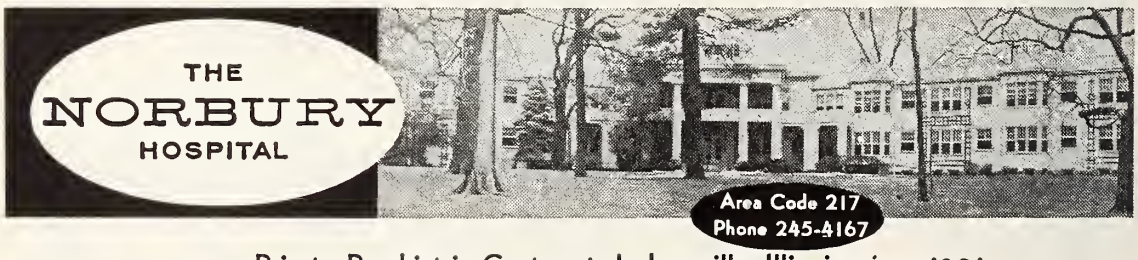
Frederick W. Storner, Jr., a former Chicagoan, died February 1, aged 30. A graduate of the University of Illinois College of Medicine in 1960, he specialized in psychiatry. Doctor Storner was a captain in the Air Force Medical Corps.

Maurice R. Williamson*, Alton, died in December, aged 72. He was a graduate of St. Louis University School of Medicine in 1917.

Herman J. H. Woehlk*, Chicago, died January 22, aged 80. He was a graduate of Chicago College of Medicine and Surgery in 1912.

Harry Wright, Metropolis, died January 14, aged 60. A graduate of the University of Illinois College of Medicine in 1946, he specialized in public health.

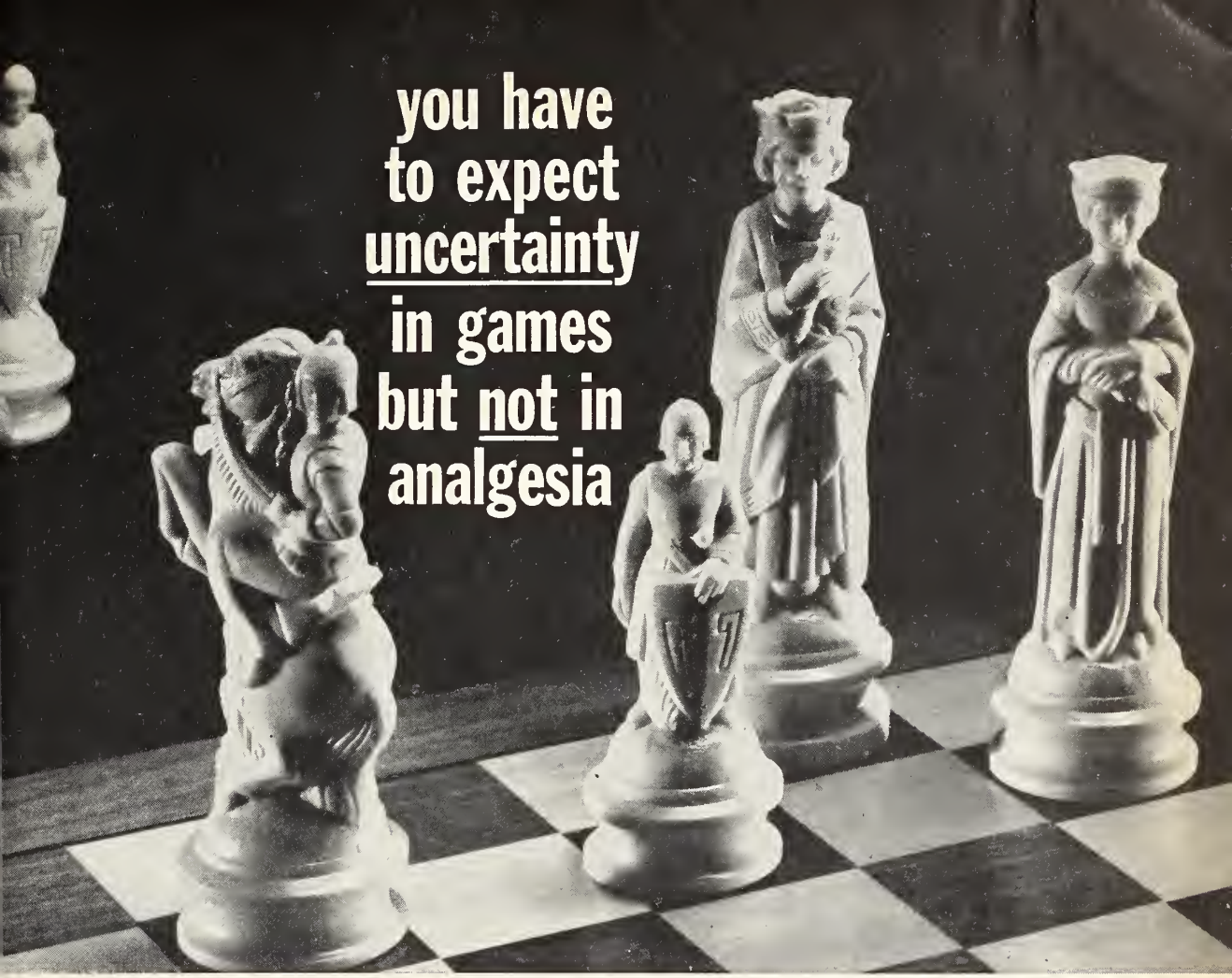
**Indicates member of Illinois State Medical Society.*



a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).



Time after time, in patient after patient, PERCODAN's pain-killing action is fast, potent and predictable. Enthusiasm for PERCODAN by physicians is almost directly proportional to their experience with this analgesic formula. Just one PERCODAN tablet usually brings relief within 5 to 15 minutes and maintains it for 6 hours or more. It rarely causes constipation.

Average Adult Dose—1 tablet every 6 hours.

Precautions, Side Effects and Contraindications—The habit-forming potentialities of PERCODAN are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias.

Also available: PERCODAN®-DEMI, each scored pink tablet containing 2.25 mg. oxycodone HCl (Warning: May be habit-forming), 0.19 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.19 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

roughout the wide middle range of PAIN...

you can rely on **PERCODAN®**

Each scored yellow PERCODAN* Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

*U.S. Pats. 2,628,185 and 2,907,768

Endo®

Literature on request

ENDO LABORATORIES INC. Garden City, New York

IMJ

Illinois Medical Journal

CONTENTS

volume 129, no. 4 *April, 1966*

ABSTRACTS OF BOARD ACTIONS....329

MEDICAL PROGRESS

Progress in Peripheral Vascular Surgery
Stanton G. Polin, M.D., Chicago....345

CLINICAL ARTICLES

Program for Negro Physicians on Hospital Staffs in Chicago
Edward Marciniak, Chicago....333

Maintenance of Postoperative Electrolyte Balance in Infants and Small Children Without Daily Blood Analysis
Thomas G. Baffes, M.D., and Magnus H. Agustsson, M.D., Chicago....339

"The Light Here Kindled"—The Story of Oak Forest Hospital
Beth Fonda....352

The View Box
Leon Love, M.D., Chicago....357

ANNUAL MEETING

Delegates' Handbook....361
Program Summary....467
Program by Days....470

FEATURES

President's Page....314
Editorials....359
Doctor's Library....498
New Pharmaceutical Specialties....500
℞ Reviews and New Products....502
IMAA Reports....506
Placement Service....509
News and Announcements....510

Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Ill. 60601. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.50 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies available at cost of 75 cents. Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.
Copyright 1966, The Illinois State Medical Society.

Mediatric®

Designed for the "metabolically spent"

Nutritional reinforcement for those who can't – or won't – eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

Conjugated estrogens-equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

Conjugated estrogens-equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic	30.0 mg.
Methamphetamine HCl	1.0 mg.

Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.



Mediatric®

steroid-nutritional compound

Ayerst

AYERST LABORATORIES, NEW YORK, N.Y. 10017 • Montreal, Canada

The president's page



Burtis E. Montgomery, M.D.

THE ANNUAL CONVENTION

It is customary for every organization to try to build attendance by claiming that this year's event—whether it be grand opera or a hog-calling contest — will be bigger and better than ever. In the case of the 126th annual convention of our society, these tried and true expressions would serve no useful purpose; the serious situation in which our profession finds itself today makes the usual slogans unfitting.

In the pages behind this one you will find the details of what is obviously a "bigger and better than ever" convention. Using the theme, "Early Diagnosis," the scientific sections have developed most promising-looking programs and the staff and committee members have put together other parts of the convention to appeal to every doctor in the state.

Without minimizing any of the above, however, I call your particular attention to the annual reports of your officers and the committees that make our society run. I firmly believe that it is the duty of every doctor in Illinois to read this material carefully. And for every delegate, one careful reading is not enough; he must familiarize himself with all of it in order to carry out his responsibilities effectively.

Being a delegate to the Illinois State Medical Society is never to be taken lightly, but now that we have the federal government involved deeply in our profession and our daily lives, it is imperative that the decisions of our House of Delegates be made with the utmost seriousness of purpose and with the most enlightened approach possible. It should, therefore, go without saying that every delegate has a moral responsibility to his home district—and his profession as a whole—to be present at every session of the House. County officers should be sure that their delegates know in advance what is expected of them at the meeting in Chicago. Here is where the business of your society is conducted and it is through your delegates that your desires and intentions can be made known through machinery at hand to enact legislation you want.

One of the most interesting sessions of the House of Delegates is sure to be the one when the Opinion Research Corporation presents the report on its findings on what Illinois doctors think about their state society and its various activities. Preliminary reports made to your Board of Trustees have been very revealing and are sure to result in some dramatic changes in direction to satisfy the membership and increase interest in the society's activities. Your delegates will want to be a part of this.

And because of the serious nature of this three-day convention, your board has decided to eliminate the annual banquet from this year's program. Instead, a party called "Salute to the Gas Light Era" has been planned for the convention's midpoint. We hope that every doctor and his wife will plan to attend.

IMJ

Illinois Medical Journal

volume 129, number 4 April, 1966

PROGRAM FOR NEGRO PHYSICIANS ON HOSPITAL STAFFS IN CHICAGO*

Our objective in Chicago in the middle 1950's was clear and unwavering equality of medical care for all our citizens, particularly for Negroes who were being denied such care. What was not so clear was the program by which such an objective could be reached. Despite evident good will among important sections of the city's civic leadership, especially at the top, we had to fumble for several years before we recognized the means necessary to our publicly acknowledged end. My presentation this afternoon will describe the process by which we framed such a program and finally carried it out.

What was the situation that confronted us in the middle 1950's? Other than at Cook County Hospital, the bulk of the city's Negro patient got their hospital care at three small and overburdened hospitals; only a handful of the city's other 65 private hospitals had Negro physicians on their staffs who could admit patients. Emergency room care—for Negroes—was hit and miss. There were cases where police and fire ambulances, carrying a Negro emergency case, would by-pass the nearest hospital—because of uncertainty about the reception that would be given the injured Negro—to reach another hospital several miles away where the reception was known to be cordial. Furthermore, a growing Negro middle class was demanding good medical care and while it was able to pay for it, was not getting it. Many Negroes who had Blue Cross-Blue Shield insurance were receiving second class service for their first class insurance dollars. Those public and private facilities which gave medical service to Negro families were overworked and overcrowded. Here, sheer quantity was undermining the quality of care. The number of Negro physicians practicing medicine in Chicago was actually decreasing; so was the number of Negro students in Chicago's medical schools. These changes downward took place at a time while the city's Negro population had risen from 278,000 in 1940 to 813,000 in 1960.

Here and there stabs were being made to push a program that would change the situation, notable among these was the pubplication of Dietrich Reitzes' book, *Negroes And Medicine*, in 1958. Conspicuous by its absence was any coordinated, top-level approach from the medical, educational, and hospital community.

Because there are two routes by which a sick or injured patient is ordinarily admitted into a Chicago hospital, via the emergency room or by arrangement of his physician, different approaches and strategies had to be devised for each of the two problems. A third question, racial segregation within a hospital once a Negro was admitted, was inevitably postponed pending resolution of the admitting problems.

* Address by Edward Marciniak, Director, Chicago Commission on Human Relations at a luncheon meeting of the Medical Section of the American Public Health Association, Conrad Hilton Hotel, Chicago, Illinois, October 19, 1965.

Hospitals involved in complaints of racial discrimination in emergency care were usually located in, or on the edge of, predominantly Negro communities. Most of their *hospitalized* patients were white, while those treated in their emergency rooms were mostly Negro. Only rarely was the Negro awaiting care in an emergency room a patient of a white physician on the hospital staff. Without the tradition of a family physician and accustomed to care in public institutions, many Negroes regarded the private hospital, and its beds, as a clinic available to them upon request.

In the case of paying patients at a private hospital, the physician played a key role. Most patients arrived in a private hospital because *their* physician, a member of its staff, made the arrangements. Thus Negroes gained admission only if their physician, frequently a Negro, held a staff appointment. Hence, a hospital appointment for a Negro physician became the master key to opening up equal opportunity for medical care for Negroes. (At no time did anyone suggest that Negro doctors must serve only Negro patients. Although most patients of Negro doctors were Negro, some Negro physicians had many white patients. And hundreds of white doctors, particularly in industrial medicine treated Negro patients.)

Another special problem was the geographic concentration of the offices of Negro doctors. Most Negro doctors practiced from offices located on the South Side —centripetal to Provident Hospital where they had staff appointments. Even though 250,000 Negroes lived north and west of Chicago's Loop, few Negro doctors had offices there. The pattern of segregated medical practice stemmed from the historic concentration of Negroes, especially those in the middle economic brackets, on the South Side, from the availability of Provident Hospital and from the non-availability of beds—to Negro patients at other hospitals.

Consequently, the south side hospitals—other than Provident—became the object of special attention by Negro doctors in search of hospital appointments. Aggravating the situation was the existence of the hospital bed shortage on the south side—compared to other sections of the city. As a result, competition among physicians for the use of these limited hospital beds was intense. White physicians did not find it easy to get appointments; Negro physicians found it extremely difficult. For those south side hospitals which were admitting some Negroes as bed patients, the appointment of a Negro physician stirred up deep fears that increased use by Negroes would result in all-Negro hospital. Even white doctors with Negro patients sometimes ran into trouble for bringing "too many Negroes" in the hospital. Accustomed to serving white patients, and occasionally surrounded by a neighborhood of Negro residents, these hospitals had to be persuaded that a hospital could be successfully integrated without becoming all-Negro. Such peaceful persuasion was often stymied by the racial bias of some influential white doctors on the hospital staff.

Hence, at the south side hospitals most convenient to them Negro doctors found less chance for an appointment than at hospitals on the near West and North sides. At precisely those hospitals less convenient to their offices and with which Negro doctors were less familiar, staff appointments were more available. Yet, these were the hospitals which seldom, if ever, had had an application from a qualified Negro physician. Later experience clearly demonstrated the truth of this situation because the first wave of staff appointments in the early 1960's came at hospitals on the near north and west sides.

As a body, Chicago's Negro doctors were an ageing group with well established patterns of medical practice. Asking them to seek other hospital appointments and thus to create *new* relationships in medical practice, was a most disturbing request—like asking a right handed man to start using his left hand on a regular basis. Somehow this problem had to be overcome also.

With a growing understanding of the problem which confronted the city, we were then able to outline a program which would ultimately guarantee equal access—without regard to race—to the medical and hospital care available in Chicago. The program we developed now follows:

Government

A. In 1956 the City Council adopted an anti-discrimination amendment to the Hospital Ordinance. Any hospital or hospital official denying admission to any person or

denying equality of care because of race, creed, or color, was subject to a fine of $100 to $200.

B. The Illinois Legislature passed legislation providing that any hospital which had been found guilty in a court of competent jurisdiction of having denied admission to a person because of his race, color or creed would lose tax exemption.

C. The City Council, with the active support of the Mayor, unanimously adopted the following resolution which set the tone and direction for future activity:

"Now, therefore, be it resolved by the City Council of Chicago that the City Council

"—Requests the Mayor to call such meetings or conferences of physicians, hospital administrators, and hospital trustees as may be necessary or desirable to take steps to end the discrimination.

"—Requests the Board of Health and the Commissioner of Health to report the measures necessary to end such discrimination.

"—Requests the Corporation Counsel to report the ordinances which the City of Chicago is authorized to enact to end such discrimination."

D. In 1962 the City Council expanded the city's hospital ordinance to prohibit discrimination in the employment or appointment of physicians on hospital staffs on account of race, color, creed, national origin, or ancestry.

E. By special arrangement with the Chicago Board of Health and with the assistance of the city's Corporation Counsel, the Commission on Human Relations took over the responsibility for investigating complaints of discrimination, for correcting discriminatory practices, and for making sure that hospitals lived up to the letter and the spirit of these laws.

F. At this point the Commission started an active file on every Negro physician in the city, including all professional information such as medical specialty, board eligibility and certification, status of hospital applications, actual appointments, etc. In this project we had the full cooperation of the Cook County Physicians Association and the Chicago Medical Society. That file became immeasurably helpful in locating physicians as the program got off the ground.

As emergency care in private hospitals improved, it became evident that a major breakthrough would have to be made for regular hospital care of paying patients by the appointment of Negro physicians to hospital staffs. To this end the Mayor convened several large meetings in his office with the city's top medical and hospital leadership. In addition, he sent a personal letter to the chiefs of medical staffs of all Chicago hospitals urging the appointment of Negro physicians.

However, progress was disappointingly slow in the five years ending September 1, 1960. On that date only fourteen hospitals out of Chicago's 68 private hospitals had a Negro physician on the staff. Most Negro doctors with staff appointments used three South Side hospitals: Provident (205 beds), Louise Burg (108 beds) and Ida Mae Scott (15 beds), all of which were crowded and serving mostly Negro patients.

While cracks were showing in the wall of hospital segregation, the barriers were still here. Something else needed to be done to capitalize on the growing demand to end, once and for all, racial discrimination in hospitals.

The Mayor's Committee

Hence, in September 1960, the Mayor appointed without any publicity a committee of leading civic, medical and hospital leaders to take advantage of the community desire for change and to obtain results by multiplying staff appointments for Negro physicians. The members of the committee were carefully chosen; professionally, they were outstanding men (for example, past presidents of the Chicago Hospital Council and Medical Society), both Negro and white. All had indicated an interest in correcting an intolerable injustice. Concerned with a carefully planned campaign to integrate hospital staffs, they sought no publicity and no credit. The committee was immediately provided with full-time assistance from the staff of the Commission on Human Relations to carry on the day-to-day follow-through.

Here is how the Committee operated:

A. Quietly, committee members requested and obtained concurring resolutions from the Chicago Medical Society and Chicago Hospital Councils that staff appointments to hospitals should be on the

basis of credentials and merit and that "prejudicial discrimination has no place in these appointments." As a result of these resolutions the problem was now being thoroughly discussed and debated widely throughout the highest levels of the hospital and medical community in Chicago.

B. By personal contact members of the committee began enlisting the support of hospital administrators, chiefs of medical staffs, hospital board members whom they knew. Through these contacts committee members probed for hospitals where appointments were possible. Wherever a favorable reception was indicated, arrangements were then made for Negro physicians who were interested and qualified to apply. Not every Negro physician was interested in a given hospital and hence many and repeated contacts were necessary. Furthermore, the informal approach was ideally suited to penetrate the "private club" atmosphere that dominated some hospitals and which characterized many hospital departments.

Five Distinct Patterns

As the Mayor's Committee moved ahead with its personal contacts five distinct patterns emerged. They were:

1. Younger Negro physicians, especially residents who had just completed their work in Chicago, were more ready to apply at hospitals with all-white medical staffs and with overwhelmingly white patient loads. Many older Negro doctors, battle-scarred from earlier acts of racial discrimination against themselves or their patients, were reluctant to place themselves again in a position where they might be wounded once again. It would be hard to underestimate the importance of the committee's efforts to encourage Negro doctors to seek a hospital staff appointment away from Provident Hospital. Some Negro doctors were easily and finally trapped by the self-fulfilling prophecy. Because they believed that staff appointments would be denied them, they did not apply. In not applying they were never appointed, and thus doors were never opened which might have been unlocked.

2. Hospitals on the near north and west sides, many with low bed censuses in pediatrics and obstetrics, were easier to integrate. These hospitals also were not subject to community pressures that feared "inundation" by Negroes.

3. Hospitals could be separated into various types that called for special approaches. In the case of public hospitals, the major effort was to encourage more Negro doctors to take the qualifying examinations. Since teaching hospitals drew most of their medical staff from the faculties of the medical schools with which they were associated, medical schools became an important avenue of integration. It was also acknowledged that residencies at such hospitals could lead to staff appointments. Priority was given by the Committee to private, not-for-profit hospitals.

4. Pioneers among the hospitals in opening up staff appointments to Negro doctors were the Jewish-related hospitals. At the time the committee started its work in 1960, and as a result of a major effort by the Catholic Interracial Council and the Archdiocesan Director of Hospitals with the support of the Catholic Archbishop, Catholic hospitals were more receptive. As the work of the Committee progressed Protestant-connected hospitals joined the parade.

5. In its approaches, the committee discovered differing patterns of success. In the Catholic hospitals, the administrator, usually a member of a religious order, was most approachable. In the Protestant-related hospitals, the contact was via the chief of a medical staff or an influential member of the staff. In the case of the Jewish-related hospitals, board members as well as physicians were found to be key people. Approaches were also made directly to the religious bodies sponsoring a given hospital for their support and cooperation.

Medical Schools Help

C. The committee then individually called on the deans of Chicago's five medical schools a) to discuss the general problem and to acquaint them with its plans, b) to discuss the process of appointing Negroes to the teaching staffs, c) to discuss recruitment of Negro medical students, and d) to get their suggestions on how the Mayor's committee could best carry on its work. During the ensuing five years direct contact was maintained with the deans of the schools. Among the results of these contacts was a substantial increase in professors who were Negroes and an interest in

new ways of recruiting potential medical students who were Negroes.

D. To enlist support for its program the Mayor's Committee or members of the staff of the Commission on Human Relations appeared before the Chicago Hospital Council, the Cook County Physicians Association, the Health Committee of the Chicago Commission on Human Relations, the Committee to End Discrimination in Chicago Medical Institutions, the annual convention of the National Medical Association, the Joint Committee of the Chicago Medical Society and the Institute of Medicine on Hospital, Patient and Staff Integration. Special meetings were held with various interested groups including the Commissioner of Health and his staff, the executive director of the Hospital Planning Council, the associate director of the Welfare Council of Metropolitan Chicago, and the Council on Equal Medical Opportunity. All of these groups were regularly kept informed about the work of the Mayor's Committee. Channels of information were kept open. Opportunities for complaints kept open. Annually each Negro doctor in Chicago was given a progress report.

E. As the committee kept pushing towards its objective, need for younger medical school graduates to knock on hospital doors became increasingly apparent. The committee, with the Commission on Human Relations providing staff and resources, launched a nation-wide campaign to alert medical school students and graduates to the expanding opportunities available in Chicago. Annually reports on changing medical opportunities were made to professional medical and hospital journals, including the Journal of the National Medical Association, the deans of Meharry and Howard Medical Schools, counselors of Southern Negro colleges, and others.

Medical Students Are Briefed

In 1962, the Commission staff called meetings of Negro medical school students, internes and residents in Chicago which were addressed by members of the committee who gave briefings on current developments so that the students, as they made decisions about where to set up practice, would make them on the basis of current information about medical opportunities in the city. Similar briefings were given to the supervising counselors in the public school system. Copies of various reprints and a brochure, "New Opportunities For Negroes in Medicine," published by National Medical Fellowships, Inc., was widely circulated by the Commission among school guidance counselors and others, like the Chicago Urban League, who were in a position to advise young Negroes on medical careers.

The group of Negro medical students, internes and residents developed into the Committee for the Advancement of Medical Education, which worked to attract additional Negro medical students to Chicago medical schools.

Subsequently, the Council on Bio-Medical Careers was set up to encourage Negro high school students to prepare for careers in medicine and has been doing an excellent job.

The Results

During the course of its five years of work the Mayor's special committee made more than 900 personal, persistent contacts. This careful, individualized attention to the problem plus prodigious follow-up effort brought results.

A. Thirty-seven hospitals for the first time added Negro doctors to their staffs. Omitting the predominantly Negro private hospitals (Provident, Ida Mae Scott, and Louise Burg) where 150 Negro doctors enjoy staff appointments there are today 45 non-governmental hospitals with Negro doctors holding 109 appointments. Some of these doctors hold employed positions as radiologists, pathologist, etc.; most of the appointments permit Negro doctors to admit their patients to the hospital.

In addition, thirty-six Negro doctors currently hold 38 appointments in 15 governmental hospitals (this includes part and full-time appointments).

The city's ten largest non-governmental hospitals, representing more than 5,600 beds, with one exception, have Negro physicians with admitting privileges on their staffs. The one exception does employ a full-time neuro-surgeon who is a Negro. Twenty-two of the city's 72 non-governmental hospitals have no Negro doctor, on the staff and no Negro resident or interne. Only two of these 22 hospitals are located in or next to a predominantly Negro community.

Out of the city's 68 non-governmental hospitals in 1960, only fifteen had a Negro physician with admitting privileges on the staff.

B. When the committee began its work, the number of physicians practicing medicine in Chicago had been steadily declining for more than a decade. That trend has been decisively reversed. In 1960 there were 215 Negro physicians; today there are 242. In the main, this rise represents new blood—younger doctors who are establishing medical careers in the city.

C. Similarly the trend in the number of Negro medical students was down from a peak of 19 in 1951 in Negro students the city's five medical schools dropped to 12 in 1962. Today the number is back at 19. With present programs we expect this figure to continue upward in the decade ahead.

D. It is among internes and residents that the greatest advance was made. In 1961 there were 16; today there are 41.

E. In 1960 Negro doctors teaching in medical schools totalled 31; today there are 42.

Anti-Trust Suit a Factor

F. A major factor in the Chicago situation was the anti-trust suit filed by ten Negro physicians charging various Chicago hospitals with a conspiracy to boycott Negro doctors and patients. A settlement was reached nearly two years ago which provided an appeal machinery for Negro doctors who claimed they were denied an appointment because of their race. Only one such complaint has been filed; and it involves a hospital that has several Negro doctors on its staff. The persistent effort of the Committee to End Discrimination in Chicago Medical Institutes should be publicly recognized.

G. Some hospitals have emerged from the "token" stage because Negro doctors on the staff have now been able to arrange that their associates also be added to the hospital staff.

H. Once Negro doctors became active on a hospital staff, it became increasingly difficult to segregate patients by floor, by wing, or by room. While the problem of room segregation by race has not been solved, it is well on its way to being removed as a sore spot in hospital policy and practice. As Negro doctors are appointed other forms of racial discrimination practiced in hospitals crumble.

I. The Commission now rarely receives complaints of racial discrimination against hospitals which have Negro personnel in their emergency room.

J. The changing situation is most painfully felt by Provident Hospital. As it seeks public support and tries to attract new medical staff, Provident Hospital is confronted with new problems as its middle income patients and their doctors make greater use of other hospitals which have opened their doors. The hospital's dilemma is clear: Can it survive as a first class hospital with a predominantly Negro medical staff and patient load *under present conditions* at the hospital and in the changing Chicago community?

What the Future Holds

What about future priorities and new program? A plentiful reservoir of Negro doctors would go a long way toward equalizing medical opportunities. That is why present counseling programs aimed at multiplying bio-medical careers are so important.

Serious problems of overcrowding in the maternity wing at Cook County Hospital were relieved in part this year by the willingness of voluntary hospitals to take indigent maternity patients who would normally have been assigned to Cook County Hospital. These referrals for which the private hospitals are reimbursed out of public funds enabled thousands of Negro women to receive maternity care in private hospitals. If this pattern continues, a major change in hospital services will have taken place.

Many hospitals ringing the city are located in suburbs; however, they serve city and suburban patients. The Commission has asked the County Board of Commissioners to appoint a similar committee to work with these hospitals. In a metropolitan area hospital needs and services crisscross political jurisdictions—making it absolutely necessary to have a single policy of hospital and medical integration for the entire metropolitan area.

MAINTENANCE OF POSTOPERATIVE ELECTROLYTE BALANCE IN INFANTS AND SMALL CHILDREN WITHOUT DAILY BLOOD ANALYSIS

Thomas G. Baffes, M.D. and
Magnus H. Agustsson, M.D./chicago

One of the major factors determining the eventual outcome of surgery in infants and particularly in premature newborns, is management of fluid and electrolyte balance in the postoperative period. That this is not a simple problem is attested to by numerous articles in the literature. Most of them use as their point of reference daily analysis of samples of the patient's blood. A number of equilibria are assumed between the intracellular and extracellular components in the patient and the changes detected in the blood are used as an indication of the type of fluids that must be administered from day to day. Because of the size of the small infant, daily venepuncture can become a serious problem. Recently, microchemical methods for analysis have largely eliminated the need for extensive blood letting. This study is not intended to replace these newer methods. It has been our rather painful experience, however, that these superb microchemical methods are not always available to every infant that has to undergo emergency surgery. Sometimes the child is born in an outlying hospital where microchemical analysis is not available. If he has sustained a neonatal catastrophe that mitigates against transfer to a pediatric surgical center, fluid and electrolyte management is a prime factor in his prognosis, for more often than not good surgical talent is available. Daily venepuncture for macrochemical analysis is a tedious responsibility for the attending pediatrician or surgeon and a potential source of anemia for the patient. Furthermore, even the finest institutions seem to develop on occasion a hiatus in the biochemical analytical services that are so imperative for good electrolyte management. This hiatus usually occurs on weekends and holidays, when trained technicians are not routinely available. Yet, the postoperative infant requires re-evaluation of his electrolyte status at such short intervals that postponement of microchemical analysis for periods of 48 to 72 hours is very hazardous. There is genuine need for a method of electrolyte management that can be used to supplement or substitute for microchemical analysis.

The notion of analyzing body excretions and fluids other than blood for electrolyte

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

management is not new. Certainly it was the basis for the original metabolic experiments underlying most principles of blood analysis in clinical use today. Adaptation of this type of analysis for direct clinical use, however, was not originally adapted because of the difficulty in collecting samples. Yet, in infants which have just undergone surgery, the situation is quite the reverse. Collection of adequate samples and accurate measurement of their total volume is easy, especially after abdominal surgery. The bowel is in paralytic ileus and loss of stool does not occur in the immediate postoperative period. Nasogastric suction is usually necessary, so collection of gastrointestinal secretions can easily be accomplished. Improved external methods for collecting urine are available or, if necessary, an indwelling catheter can be inserted into the bladder. Thus, all fluids lost during the postoperative period—urine and gastrointestinal secretions—can be accurately collected, measured and sampled. The only other factor to be considered is insensible water and salt loss. This is an assumed value in almost any method of fluid and electrolyte control in use today.

Accurate recording of patient intake and output is done well by the nursing staff in almost every hospital. Collection of aliquot portions of each body fluid can be accomplished and sent to the laboratory for analysis. Since these fluids are to be discarded anyway, ample amounts are available for gross chemical analysis. This type of analysis is available in almost all hospitals, and is also available on an emergency basis at all times. With the data derived by these analyses, it is easy to calculate the total amount of each electrolyte loss. These losses can then be replenished intravenously.

Case Reports

Seventeen patients have had postoperative fluids and electrolyte controlled by analysis of urine and gastrointestinal secretions rather than by daily venepuncture and microchemical blood analysis. The type of patients involved are listed in Table I. They were collected from several institutions over a period of about four years. Although this type of control was used of necessity because daily blood microanalysis was not available, blood samples were drawn and tested whenever possible, in order to substantiate the efficiency of this method. In none of these patients were any serious difficulties encountered. The control blood chemistries, whenever they were available, were well within acceptable normal limits.

TABLE I

TYPES OF CASES TREATED BY ANALYSIS OF URINE AND G. I. SECRETIONS

Hypertrophic Pyloric Stenosis	3
Imperforate Anus	3
Malrotation	2
Volvulus	2
Oomphalocoele	2
Perforated Gastric Ulcer	1
Diaphragmatic Hernia	1
Hirschsprung's Disease	1
Ruptured Spleen (Traumatic)	1
Ruptured Liver (Traumatic)	1
TOTAL CASES	17

In each instance, urine and gastrointestinal secretions were allowed to accumulate in the collecting vesicles for twenty-four hours, then they were removed and carefully measured. Since the volumes were frequently small (100 to 200 cc.) the entire sample was usually sent to the emergency laboratory. If the specimens amounted to more than 200 cc., an aliquot portion was sent to the laboratory and careful notation was made of the total volume represented. These samples were analyzed by whatever methods were within the capabilities of the emergency crew. Where possible, duplicate or triplicate analyses were made to confirm the accuracy of the determinations. This repeat analysis was no problem because of the copious samples that were available.

Since the laboratory determinations were presented in terms of milli-equivalents per liter of sample, it was a simple matter to draw up a proportion and thereby determine the total milli-equivalents of a given ion in each sample, as follows:

$$\text{observed } \frac{\text{mEq.}}{\text{Liter}} = \frac{\text{x (unknown mEq.)}}{\text{total vol. of sample}}$$

From these calculations, the total milli-equivalents of a given ion lost in the urine and in the gastrointestinal secretions could

be determined by simple addition. Since the content in milli-equivalents of each ion in standard intravenous solutions is known, it was equally simple to determine how many cubic centimeters of a given standard solution would be required to provide the required milli-equivalents of a given ion to replenish the total loss. To illustrate, the following two case reports are presented.

Case I

B. T. was born precipitously in his mother's bed on Friday evening, February 21. Spontaneous respirations began at once, but the baby had a ruptured oomphalocoele and the major portion of the intestine lay free outside the coelomic cavity. The weight of the intestine had kinked the superior mesenteric artery and the viability of the bowel was questionable. The nurse in attendance, however, had the presence of mind to support the bowel in good position with warm saline packs and there was some hope for the baby. The child was quickly taken to the operating room and the ruptured oomphalocoele was repaired. The color of the bowel improved as it lay in the coelomic cavity and the operative procedure was tolerated remarkably well. Because the event occurred at the onset of the weekend, all the laboratory technicians were not available and we were faced with the prospect of managing fluid and electrolyte balance in a critically ill infant with emergency personnel. We decided to use indirect control by analysis of the urine and gastrointestinal fluid. Blood samples were drawn at the beginning and the end of the critical postoperative period to check the effectiveness of this method of control. The data observed and the intravenous fluids given are outlined in Table II. The detailed calculations from the data were as follows:

On the first postoperative day, February 22, the patient lost 105 cc. of gastrointestinal secretions with a sodium level of 144 mEq./L, a chloride level of 102 mEq./L and a potassium level of 7.5 mEq./L. He lost no urine. Because of his anuria, it was decided not to give him intravenous potassium that day. The amount of saline to be administered was estimated using the chloride level. (The sodium level might have been used as well, but we chose the chloride level because it was lower.) The proportion used for calculation was as follows:

$$\frac{102}{1000} = \frac{x}{105},$$

$$x = \frac{102 \times 105}{1000} \text{ or } 10.7 \text{ mEq. } Cl^-$$

Since normal saline solution has 15.5 mEq. sodium or chloride per hundred cubic centimeters, the amount of normal saline to be given was calculated at 69 cc. The patient weighed 3 lbs. 12 oz. (1.7 Kg.). Since his daily fluid requirements (at 100-150 cc./Kg.) amounted to 170-250 cc., the patient received 150 cc. 5% dextrose in distilled water in addition to the normal saline. Urinary output began that night.

TABLE II

Date	*Blood* K	Na	Cl	CO_2	*Urine* K	Na	Cl	CO_2	Vol.	*G. I. Secretions* K	Na	Cl	CO_2	Vol.	*I. V. Fluids* 5% Dext.	N.S. (C.C.)	KCl mEq.	Remarks
	(mEq./L)				(mEq./L)				(cc.)	(mEq./L)				(cc.)				
2/22										7.5	144	102	105		150	69		
2/23					36	too low	12		65	4.4	123	85	50		150	40	3	Solu-Cortef 2.5 Mg. q.i.d.
2/24	5.9	143	96	18.8	31	24	22		85	8.5	133	98	64		150	50	2	Solu-Cortef 2.5 Mg. q.i.d.
2/25	5.8	143	98	16.9	20	25	21		45	6.4	120	89	113		150	70	0	Aquamephyton 0.1 Mg. (Peristalsis) (Having Stools)
2/26	4.5	138	96	17.0	10	36	38		30	9.9	32	119	15		150	30	2	Het. 62 Hgb. 20
2/27	4.3	144	95	16.8	15	26	27			8.2	130	103			150			Nasogastric tube out; oral dextrose.
2/28	4.9	144	97	16.9	1.8	qns	15											Skim Milk by mouth.

On the second postoperative day, February 23, the urinalysis showed high potassium output and sodium retention. It was decided to give the patient solu-Cortef, 2.5 mg. q.i.d. The patient put out 50 cc. of gastrointestinal secretions with a sodium level of 123 mEq./L and a potassium level of 4.4 mEq./L. The urinary output amounted to 65 cc. with a potassium level of 36 mEq./L. and a sodium level too low to be read. The following calculations were done:

Sodium Loss:

$$\frac{123}{1000} = \frac{x}{50},$$

$$x = \frac{123 \times 50}{1000} = 6.2 \text{ mEq.} = 40 \text{ cc. N.S.}$$

(Urinary loss nil.)

Potassium Loss:

Urine:

From 2/22: $\frac{7.5}{1000} = \frac{x}{105}$,

$$x = \frac{7.5 \times 105}{1000} = 0.79 \text{ mEq.}$$

From 2/23: $\frac{4.4}{1000} = \frac{x}{50}$,

$$x = \frac{4.4 \times 50}{1000} = 0.22 \text{ mEq.}$$

G. I. Secretions:

From 2/23: $\frac{36}{1000} = \frac{x}{65}$,

$$x = \frac{36 \times 65}{1000} = 2.34 \text{ mEq.}$$

The potassium loss estimated by adding the above figures amounted to 3.35 mEq. The patient received 3 mEq. in his solutions, which amounted to 40 cc. normal saline and 150 cc. 5% dextrose in distilled water.

The same types of calculations were conducted for February 24 and 25, and the fluids given are listed in Table II. By the fifth postoperative day the patient developed peristalsis and oral feeding was begun. It was progressively increased until intravenous fluids could be discontinued on the seventh postoperative day. Blood chemistries taken on February 26, the fifth postoperative day, indicated excellent electrolyte balance. It was of great interest to us that chemical analysis of the urine on the first and second postoperative days demonstrated adrenal insufficiency which responded to administration of cortisone.

Case 2

N. B., a premature female infant weighing 4 lbs. 2 oz. was born precipitously on February 19, 1962, following an abruptic placenta. The baby was well until February 25, when she began to have bouts of recurrent and recrudescent abdominal distention accompanied by cyanosis. On February 27, signs and symptoms of intestinal obstruction became unmistakable and we saw the baby in consultation. On physical examination there was definite persistent abdominal distention with tenderness and a palpable mass in the right upper and right lower quadrants. The vomitus was green and fairly copious. Emergency laparotomy was performed that evening. Intestinal stenosis was found at the junction of the middle and lower third of the small intestine. A 360° volvulus had occurred at the base of the stenotic loop and gangrene had resulted in about six inches of adjacent small bowel. The volvulus was corrected, the gangrenous bowel was resected and an ileojejunostomy was done. The laparotomy was closed.

TABLE III

Date	*Blood* K	Na (mEq./L)	Cl	CO_2	*G. I. Secretions* K	Na (mEq./L)	Cl	CO_2	Vol. (cc.)	*Urine* K	Na (mEq./L)	Cl	CO_2	Vol. (cc.)	*I. V. Fluids* 5% Dext.	N.S. (C.C.)	KCl mEq.	Remarks
2/28	18.8	131	106	qns	2.8	43	44		116	4.6	25.2	15	136		125	55		
3/1					4.8	48	71		155	2.2	41.5	71	160		125	90	1	
3/2					7.5	75	88		80	2.0	60	8	130		125	80	1	
																		Dextrose by mouth
3/3	4.7	137	106							4.2	22	20	90		125	50		Milk p.o.
3/4															125			

On February 28, about 12 hours after operation, the patient had lost (Table III) 116 cc. of gastrointestinal secretions with a sodium level of 43 mEq./L, a chloride level of 44 mEq./L and a potassium level of 2.8 mEq./L. Urine loss amounted to 136 cc., with a sodium level of 25.2 mEq./L and a potassium level of 4.6 mEq./L. Replacement of ions was estimated as follows:

Sodium Losses:

$$\text{Urine:}\quad \frac{25.2}{1000} = \frac{x}{136},$$

$$x = \frac{25.2 \times 136}{1000} = 3.43 \text{ mEq.}$$

$$\text{G.I.:}\quad \frac{43}{1000} = \frac{x}{116},$$

$$x = \frac{43 \times 116}{1000} = 4.9 \text{ mEq.}$$

Total sodium loss was about 8 mEq. or 52 cc. of normal saline (calculated @ 15.5 mEq. Na per 100 cc. normal saline).

Potassium Losses:

$$\text{Urine:}\quad \frac{4.6}{1000} = \frac{x}{136},$$

$$x = \frac{4.6 \times 136}{1000} = 0.62 \text{ mEq.}$$

$$\text{G.I.}\quad \frac{2.8}{1000} - \frac{x}{116},$$

$$x = \frac{2.8 \times 116}{1000} = 0.32 \text{ mEq.}$$

Total potassium loss was estimated at 0.9 mEq., the sum of the two above values. Because the initial blood sample showed elevated potassium and because adequate urination had not been established no potassium was given that day. The patient received 55 cc. of normal saline and 125 cc. 5% dextrose in distilled water. This totalled 180 cc. of fluid and satisfied the estimated daily requirement of 150-200 cc.

For the next two days the same type of calculations were carried out. On Mareh 1 (Table III), gastrointestinal secretions amounted to 155 ee. with a sodium level of 48 mEq./L and a potassium level of 4.8 mEq./L. The urine output was 160 cc. with sodium level of 41.5 mEq./L and potassium level of 2.2 mEq./L. Sodium loss was estimated at 14.0 mEq., indicating need for approximately 90 cc. normal saline for replacement. Potassium loss amounted to 1.09 mEq. The patient received 90 cc. normal saline, 1.0 mEq. potassium and 125 ee. 5% dextrose in distilled water.

Similar calculations for March 2 led to administration of 80 cc. normal saline, 1.0 mEq. potassium and 125 cc. 5% dextrose in distilled water. On March 3, blood samples were taken and indicated good fluid and electrolyte balance. The patient also began oral alimentation. Postoperative recovery continued to be good and in ten days she was discharged from the hospital.

Discussion

We hesitated for quite a while before presenting this concept of indirect control of fluid and electrolytes, lest it be misinterpreted as an attempt to replace the well aecepted method of control by daily microchemical analysis of blood. This is not our intent. However, during the past four years some seventeen infants have had emergency operations under circumstances in which complete microchemical analysis of blood was not available for the entire critical immediate postoperative period. In many of these cases, this method of indirect control by analysis of urine and gastrointestinal secretions was instrumental in bring about a successful outcome.

Perhaps the most significant point being made is that there is another possible method for evaluating fluid and electrolyte therapy. It is readily available in the laboratories of almost any hospital and can be an effective substitute for mierochemical analysis of blood samples. It is our hope that this method may serve as a useful tool in combination with microchemical analysis of blood in order to provide more aceurate fluid and electrolyte therapy in these critically ill patients. The two case reports offer testimony favoring joint use of these two methods. In Case 1, analysis of urine potassium and sodium in the first postoperative day detected adrenal insufficiency that responded to cortisone therapy. This may not have been detected so early by blood analysis alone. In Case 2, initial blood analysis deteeted hyperkalemia whieh required caution in the ad-

ministration of intravenous potassium in the immediate postoperative period.

Finally, the addition of analysis of urine and gastrointestinal secretions to the armamentarium used in the immediate postoperative period does not add greatly to the complexities of patient care. These samples are collected routinely in the postoperative period for measurement of intake and output. They need only be collected as mixed specimens for longer periods of time and aliquot portions sent to laboratory for analysis. Since the secretions are to be discarded anyway, there is no threat to the patient's hemostasis and there is no limit to the fraction of the specimens that may be sent to the laboratory.

Acknowledgment

The authors wish to acknowledge the generosity of the pediatricians at Lutheran General Hospital, Illinois Central Hospital, Swedish Covenant Hospital and Augustana Hospital who gave permission for publication of case histories of these patients.

POSTGRADUATE MEDICAL EDUCATION EXPANDING

Most physicans continue to study medicine long after entering practice—and the number of postgraduate medical courses available to them has increased nearly 50 per cent in the past five years.

This year, 1,641 courses are being offered in 40 states and the District of Columbia, reports a recent issue of the Journal of the American Medical Association. The issue contains the 65th annual report on medical education by the AMA's Council on Education.

The number of physicians registered in these courses may be over 150,000.

Attending courses, however, is only one of the ways a doctor continues his education, the Journal points out. Most physicians rank their continued reading of medical literature as one of their most important sources of new knowledge.

They also continue their education through professional contacts with other physicians, and through hospital staff meetings and national, state and local medical society meetings.

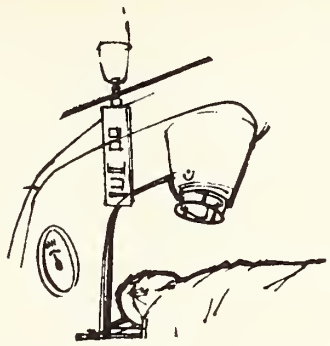
Formal postgraduate courses, however, are becoming increasingly important. Medical schools continue to be the major sponsors, but courses also are offered or co-sponsored by medical societies, voluntary health agencies, hospitals, and governmental health agencies.

The most popular subject when doctors return to class? Psychiatry, by a wide margin. Courses in general medicine come next. Special subject areas such as pathology, surgery, ophthalmology, obstetrics-gynecology, and cardiovascular disease also are popular.

Figures are not now available on the total number of physicians attending continuing education courses. Partial figures indicate that there has been a marked increase since last year.

During the 1964-65 academic year, there were 88,845 registrations at courses sponsored by medical schools, Medical schools sponsor about half the courses. If attendance at other courses was similar, the total registration last year must have exceeded 150,000, the Journal said.

Medical Progress



Harvey Kravitz, M.D./progress editor

PROGRESS IN PERIPHERAL VASCULAR SURGERY

Stanton G. Polin, M.D./chicago

In the past decade it has been established that revascularization is feasible and technically possible in almost any diseased major vascular bed.[1] Fewer articles now appear in the literature about isolated "spectacular" vascular surgical feats and more deal with an analysis and evaluation of the outcome of the various operations.

Vascular surgery can frequently cure or improve two major categories of arterial disease:

1. aneurysms
2. occlusive lesions

The etiology in both categories may be:

1. congenital
2. degenerative (mostly arteriosclerosis)
3. inflammatory
4. traumatic

It is not generally realized that vascular lesions, whether aneurysm or occlusion, are frequently segmental in nature with a relatively uninvolved arterial tree proximal and distal to the lesion.[2] The crucial factor in determining whether the lesion is correctible is a good inflow from the proximal arterial tree and outflow into the distal arterial tree.

Arteriosclerosis is the most common cause of aneurysms and occlusive lesions, but it should be noted that the physiologic impairment created by an occlusion is similar whether it is due to atherosclerotic narrowing (degenerative), coarctation (congenital), etc. Therefore, the principles of treatment for occlusive disease are similar regardless of the etiology and the same general rules apply to aneurysms regardless of their etiology.

The operations that are applicable to vascular disease are:

1. Bypass
2. Resection of the lesion and replacement
3. Thromboendarterectomy with or

Department of Surgery, Michael Reese Hospital and Medical Center, Mt. Sinai Hospital and Medical Center, St. Joseph Hospital, Lutheran Deaconess Hospital, Forkosh Hospital, Chicago Medical School.

without patch graft
4. Sympathectomy

The following non-surgical treatments are occasionally used but will not be discussed here:

1. Anticoagulants
2. Fibrinolysin
3. Low Molecular Weight Dextran
4. Hyperbaric Oxygen

Bypass

This method restores arterial flow around the point of obstruction with either a synthetic tube (Dacron or Teflon) or a segment of autogenous vein. The bypass procedure requires anastomosis of the tube proximal and distal to the obstruction. It leaves collateral vessels intact so that if the bypass becomes occluded or otherwise fails to function the collateral vessels prevent the patient's condition from becoming worse than before surgery.

The Dacron and Teflon prostheses now in use have been proven satisfactory during 10 years experience. Other synthetic materials or arterial homografts are no longer used.

Saphenous vein is an excellent arterial substitute for small arteries. The vein is reversed to prevent obstruction to blood flow by the venous valves as described by Cate[3] or the valves must be destroyed. A recently described method of Connolly and co-workers of leaving the saphenous vein in situ[4] for femoropopliteal bypass has the advantages of no diserepaney in size between the proximal anastamosis and distal anastamosis and the vein remains completely viable, thus decreasing the ineidenee of thrombosis in the graft.

Resection and Replacement

Reseetion is necessary for aneurysms which otherwise are a source of emboli. The artery is then reconstituted with a prosthetic graft.

Thromboendarterectomy With or Without Patch Graft

Flow may be restored to normal in some cases by removing the obstructing atheroma on the intima and preserving the outer layers of the artery whieh remain the conduit for blood flow. The basic principles explained by Wylie are the removal of all fragments that may cause rethrombosis and creating a smooth transitional zone at the distal end of the endoarterectomy.[5]

In closing arteriotomies of small arteries it is desirable to utilize a patch of vein or synthetic material to increase the size of the lumen. This results in an increase in the circumference equal to the width of the patch and is commonly used by De Bakey and others.[6]

Sympathectomy

Interruption of the sympathetic chain in the treatment of vascular occlusion in the extremity is occasionally useful to release vasomotor tone and thereby increase arterial flow. Sympathectomy does not influence the progress of the underlying disease but it is eredited with helping to preserve a limb,[7] limit amputation,[8] give comfort to the patient,[9] and even inerease walking distance in ischemic limbs.[10] The increased flow is smaller than can be achieved by thromboendarterectomy or bypass.

Aneurysms

Considerable progress has been made in the treatment of aortic aneurysms sinee the first one was successfully resected and replaeed by Dubost in 1952.[11] Since then aneurysms of all portions of the aorta and its major branches have been suceessfully resected and replaced.

The major complieations associated with the surgery of aneurysms have been reeognized and improved. False aneurysm formation and breakdown of the suture line has resulted from deterioratiou of the silk suture material.[12] Now newer sutures such as Mersiline or Polyethylene are utilized and this loss of tensile strength does not oecur. Rupture of the anastamotic line into the duodenum, a subjeet reviewed by Cordell,[13] is now prevented by interposing tissue between the suture line and intestine. The mechanism of renal shutdown that sometimes occurs after aortic surgery is still not well understood. Beall has discussed the eontrol of hydration and/or Mannitol induced osmotic diuresis[14] to overcome this oliguria.

These measures have helped to decrease the operative mortality for elective resection of thoracic aneurysms to 10-15% and of abdominal aneurysms to less than 5%. The five year survival of patients treated by elective resection of their abdominal

aneurysms, including the operative mortality, is 62% as compared with a five year survival of 10% in untreated patients and 86% in the population of comparable age and sex without aneurysms.[15, 16] Series from various medical centers show an even greater mortality rate for those with untreated aneurysms.[17, 18, 19] Furthermore, the mortality rate attending surgery for a ruptured aortic aneurysm is more than four times greater than that associated with planned resection.[20, 21] Therefore, except in rare circumstances, the proper treatment of aortic aneurysm is resection.

Thoracic aneurysms provide a greater operative risk than abdominal aneurysms, as Vasko points out, but the mortality rate of thoracic aneurysms that are untreated is considerably higher than of untreated abdominal aneurysms.[22] Resection of a thoracic aortic aneurysm requires some adjunctive measure to protect the brain, spinal cord and kidneys from ischemia, and to prevent overloading of the left ventricle.[23] Ascending aortic aneurysms can be handled with total cardiopulmonary bypass and coronary perfusion; arch aneurysms with temporary ascending to descending aortic bypass and shunts up to the carotid arteries; descending aortic aneurysms with partial circulatory bypass from the left atrium to femoral artery. These techniques have been worked out by the Baylor University group.[24]

Dissecting aneurysms have the problem of involving potentially long segments of aorta. They almost always dissect in a forward direction but not uncommonly dissect in a retrograde direction. In fact, Engell[25] and Rohman[26] showed that death is often due to occlusion of the coronary artery ostia or incompetence of the aortic valve secondary to prolapse of aortic cusps into the left ventricle. In Hume's[27] and Hirst's[28] series the interval between onset of symptoms and death was several hours. allowing enough time for diagnosis and treatment. The treatment varies depending on the location and extent of the dissection.[29]

Abdominal aneurysms are more straightforward. 95% are situated below the renal arteries.[30] Occlusion of the aorta below the renal arteries is well tolerated for long periods of time and no provision for temporary bypass is required.[2] Not uncommonly the common iliac arteries are involved in the same aneurysmal process as the terminal aorta. In the latter case a bifurcation graft is used to replace the involved arteries.

Peripheral aneurysms can occur at any level. The principle of extirpation and replacement applies here just as it does for aortic aneurysms. The most common peripheral aneurysm is found in the popliteal artery.[31] In addition to the possibility of rupture, it commonly is the source of distal embolization and even of dissection as Mowitz described.[32]

Occlusive Disease

Occlusive lesions differ from aneurysms in that the mere presence of the latter is a threat to life whereas the danger of the former lies not in the lesion itself but in its obstructive effects on the circulation. If the occlusion in a major artery occurs slowly, it is possible that sufficient collaterals will develop to prevent symptoms. However, if the occlusion occurs acutely in a major artery, symptoms are sure to follow.

Acute arterial occlusion in a major vessel is a surgical emergency. In this day of progressive surgery it is no longer sufficient only to maintain viability of a limb but rather it is important to restore function. Cranley described a variety of embolectomy methods that can be done with little risk under local anesthesia.[33]

Cerebral Arteries

Diminished cerebral blood flow due to extracranial carotid or vertebral artery disease accounts for 25 to 40 per cent of all strokes. Multiple lesions, involving both carotid artery bifurcations and vertebral artery origins are common. In fact, whether or not single or multiple lesions will even cause symptoms of cerebral insufficiency depends, as DeBakey emphasized, on the extent of collateral circulation derived from both intracranial and extracranial communications.[34]

Although narrowing from atheroma is the lesion most commonly seen, obstruction due to kinking of a tortuous carotid artery may be another cause. This has been described by the Baylor University group[35] as well as others.[36]

Another lesion causing signs and symptoms of cerebrovascular insufficiency is the

subclavian steal syndrome.[37, 38, 39] It is due to occlusion of the innominate or the first portion of the subclavian artery so the blood pressure in the distal subclavian artery is lower than the pressure in the vertebral basilar system. Therefore, blood flows in a retrograde fashion in the vertebral artery away from the brain.

Celiac and Superior Mesenteric Artery Insufficiency

Intestinal angina is a symptom of intermittent gastrointestinal ischemia just as angina pectoris is a symptom of intermittent myocardial ischemia. Typically, the intestinal angina develops with the maximal work load following meals.

It is rare for isolated celiac axis stenosis to give symptoms because collaterals from the superior mesenteric artery are rich. Also, the liver derives blood from the capsular arteries, the stomach from the inferior phrenic artery, and the spleen will shrink and undergo fibrosis.

Spontaneous inferior mesenteric artery occlusion is rare. However, vascular impairment of the left half of the colon may occur following an operation on the abdominal aorta, especially when the inferior mesenteric artery is sacrificed.[40]. The collaterals from the hypogastric artery usually protect the sigmoid, but when this vessel is diseased, the collateral supply and, consequently, the protection is removed. Treatment of inferior mesenteric artery insufficiency must be vigorous. Surgical treatment consists of resection of the left colon with or without proximal colostomy.[41] There have been no reported instances of surgical repair of the inferior mesenteric artery according to Laufman's comprehensive review.[42]

Atherosclerosis of the celiac or superior mesenteric arteries almost always only affects the proximal two to three cm with the remainder of the vessels fairly normal. This significant observation was made by Fry and Kraft.[43]

The treatment can be thromboendarterectomy, prosthetic or autogenous bypass graft from the distal aorta, or re-implantation of the superior mesenteric artery into the aorta.

Damping of the pulse pressure in the renal artery may cause hypertension. The most common lesion in order of frequency causing alteration of renal blood flow as encountered by DeBakey are atherosclerosis, fibromuscular hyperplasia, and renal artery aneurysms.[44] An interesting but rare lesion is coarctation of the abdominal aorta in a suprarenal position.[45]

Atherosclerosis involves the ostia or proximal third of the renal artery in 75 per cent of cases.[46] Fibromuscular hyperplasia involves most of the length of the main renal artery but spares the primary branches.[47] Aneurysms are usually saccular. The foregoing findings help to determine the surgical approach.

A variety of procedures can be done but the technique used must be adapted to each individual case involved.[48] Atherosclerosis is almost always treated by thromboendarterectomy with patch angioplasty or bypass graft. Fibromuscular hyperplasia must be treated by bypass graft with the distal anastamosis sometimes done on a primary branch. Aneurysms are treated by aneurysmorrhaphy because of the sacciform nature of the lesion. In rare situations splenorenal arterial shunts are performed and sometimes resection of a segment of involved renal artery and reanastamosis is carried out.

In all cases the object of surgery is to remove any pressure gradient across the renal artery (damping of the pulse pressure). Accordingly, it is important to measure the pressure gradient before and after the vascular reconstruction.

Results from various centers show a high rate of cures or improvements.[44, 49, 50] However, there is controversy as to which hypertensive patient with a renal artery abnormality is a candidate for revascularization. Careful selection will yield a higher cure rate.

Aortoiliac and Femoropopliteal Arteries

Occlusions in the aortoiliac or femoropopliteal arterial segments manifest themselves by intermittent claudication. As long as there are good collateral vessels the claudication may be minimal, even in the absence of palpable peripheral pulses. However, with poor collaterals the pain progresses to the point where it is even present at rest. The end stage of ischemia is gangrene.

Recent medical literature is replete with discussions concerning the best method for

revascularizing the termial aorta and the distal arterial tree. The technical methods available are bypass, thromboendarterectomy with or without patch, and sympathectomy.

The aortoiliac segment differs from the femoropopliteal segment in two major ways that affect revascularization. In the former there is less bending of the arterial tree, especially since in the latter the artery crosses the groin and knee. Also, the aortoiliac arteries are larger than the latter and the blood flow rate is higher.

If the aortoiliac disease is limited to a short segment, then most surgeons prefer thromboendarterectomy with patch angioplasty.[2, 51, 52] But when the aortoiliac disease is extensive, some surgeons do bypass grafts.[2, 53]

Femoropopliteal Disease

One problem that arises in patients with aortoiliac disease is the frequency of concomitant femoropopliteal disease.[54] Long bypass grafts starting on the aorta and ending on the popliteal artery have a high incidence of failure. It has been shown by work in three different centers that endarterectomy of the orifice of the profunda femoris artery and revascularization of this artery with a graft gives excellent results and even a high rate of restoration of pedal pulses.[53, 55, 56]

In poor risk patients it is feasible to pass a graft subcutaneously from the axillary artery to the profunda femoris artery. Although the graft is long and it undergoes considerable bending, the procedure has been repeatedly successful.[57, 58] If the disease is limited to one iliac artery, then an alternative conservative safe procedure is to tunnel subcutaneously a graft from the femoral artery that receives a good flow across the abdominal wall to the femoral artery on the side of the affected iliac artery.[59]

Vascular reconstruction in the leg does not give as good long-lasting results as elsewhere in the arterial tree. Wylie says this is due in part to the prevalence of obstructive lesions in the outflow vessels in so many cases,[60] and in part to the smaller caliber of the leg arteries.

Endarterectomy, particularly of short segments, is a useful procedure in the leg. It must be done meticulously and no loose intima may be left behind. The long term success of endarterectomy can be enhanced by two different methods. Edwards[61] and Hall[62] use vein patches to enlarge the caliber of the vessel. Creation of an arteriovenous fistula between the distal end of the endarterectomized segment and an adjacent vein will help to maintain blood flow through that arterial segment during the period that a new intima grows in (the time that thrombosis is most likely to occur). This method has been used clinically with success by Root and Cruz.[63] There are no deleterious effects produced by the fistula.

Bypass is the other method of revascularizing the femoropopliteal area. There is controversy over the proper type of graft material to use. Initial success is reported in equal frequency with the use of vein grafts or prostheses. More groups favor vein grafts in the leg than prosthesis and Darling[64] goes so far as to say that a prosthesis should never be used below the inguinal ligament.

Prostheses are more readily available than vein grafts of required length. Some report excellent results with Dacron tubes.[65, 66]

Veins have the advantage of maintaining flexibility and of not behaving like a foreign body in event of an infection. Proponents for vein grafts also report excellent results.[31, 67]

Dotter recently described a method of treating atherosclerotic stenosis or occlusion of the femoral or popliteal artery by transluminal dilatation with catheters of varying sizes.[68] This method has salvaged limbs that were ready for amputation. It bears watching to see the long term results.

Sympathectomy is sometimes used as an adjunct with one of the foregoing revascularization procedures on the leg or is used by itself in situations where the runoff is too poor to permit revascularization. The physiologic basis of sympathectomy in atherosclerosis has been debated repeatedly.

Summary

This paper is a presentation of the major efforts in reconstructive vascular surgery as it is practiced today. The field is constantly undergoing changes. In fact there are a variety of surgical proeedures that can be done for each type of major vessel disease and only the passage of time and

careful scrutiny of data will help to reveal the best methods of managing different problems. It is hoped that the reader has gained an understanding of the problems and a realization that modern surgical techniques are availabe to cope with them.

References

1. Shaw, R. S., Reconstructive Vascular Surgery, *New Eng. J. Med.* 266:339, 1962.
2. DeBakey, M. E., Basic Concepts of Therapy in Arterial Disease, *J.A.M.A.* 186:484, 1963.
3. Cate, W. R., Jr., Bypass Grafts in Small Arteries: Experimental Comparison of Freeze Dried Arterial Homografts, Autogenous Vein and Crimped Dacron, *Am. Surgeon* 25:523, 1959.
4. Connolly, J. E., Harris, E. J., Mills, W., Jr. Autogenous In Situ Saphenous Vein for Bypass of Femoral-Popliteal Obliterative Disease, *Surgery* 55:144, 1964.
5. Wylie, E. J., Binkley, F. M., and Albo, R. J., Femoropopliteal Endarterectomy, *Am. J. Surg.* 108:215, 1964.
6. DeBakey, M. E., Crawford, E. S., Cooley, D. A., Morris, G. C., Jr., Surgical Considerations of Occlusive Disease of Innominate, Carotid, Subclavian and Vertebral Arteries, *Ann. Surg.* 149:690, 1959.
7. Shaw, R. S., Austen, G., Stipa, S., A Ten Year Study of the Effect of Lumbar Sympathectomy on the Peripheral Circulation of Patients with Arteriosclerotic Occlusive Disease, *Surg., Gynec., and Ob.* 119:486, 1964.
8. Blain, A., Zadek, A. T., Teves, M. L., Bing, R. J., Lumbar Sympathectomy for Arteriosclerosis Obliterans, *Surgery* 53:164, 1963.
9. Paloschi, G., and Lynn, R. B., Role of Sympathectomy in Treatment of Obliterative Peripheral Vascular Disease, *Canad. Med. J.* 90:1147, 1964.
10. Mackenzie, D. C., Lowenthal, J., Lumbar Sympathectomy and Claudication Distance, *Surg., Gynec., and Ob.* 115:303, 1962.
11. Dubost, C., Allary, M. and Occonomos, N., Resection of An Aneurysm of the Abdominal Aorta, *Arch. Surg.* 64:405, 1952.
12. Britt, C. I., Miller, E. M., Jr., Felder, M. E., and Sirak, H. D., Comparative Reaction of Mersilene and Silk Sutures Implanted within the Heart, *Ann. Surg.* 153:52, 1961.
13. Cordell, A. R., Wright, R. J., Johnston, F. R., Gastrointestinal Hemorrhage After Abdominal Aortic Operations, *Surgery* 48:997, 1960.
14. Beall, A. C., Jr., Hollman, M. R., Morris, G. C., Jr., DeBakey, M. E., Mannitol-Induced Osmotic Diuresis During Vascular Surgery, *Arch. Surg.* 86:34, 1963.
15. Moore, S. W., Wantz, G. E., Jr., Abdominal Aortic Aneurysm, *S. Clin. North America* 41:497, 1961.
16. MacVaugh, H. Roberts, B., Results of Resection of Abdominal Aortic Aneurysm, *Surg., Gynec. and Obst.* 113:17, 1961.
17. Estes, J. E., Abdominal Aortic Aneurysm: A Study of One Hundred and Two Cases, *Circulation* 2:258, 1950.
18. Blakemore, R. H., and Vorhess, A. R., Jr., Aneurysm of the Aorta: A Review of 365 Cases, *Angiology* 5:209, 1954.
19. Gliedman, M. L., Ayers, W. B., and Vestal, B. L., Aneurysms of the Abdominal Aorta and Its Branches, *Ann. Surg.*, 146:207, 1957.
20. Gryska, P. F., Wheeler, C. G., Linton, R. P., A Review of Seven Years Experience with Excision and Graft Replacement in 150 Ruptured and Unruptured Aneurysms of the Abdominal Aorta, *New Eng. J. Med.* 264:639, 1961.
21. Voorhees, A. B., Jr., McAllister, F. F., Long Term Results Following Resection of Arteriosclerotic Abdominal Aortic Aneurysms, *Surg., Gynec., and Ob.* 117:355, 1963.
22. Vasko, J. S., Spencer, F. C., Bahnson, H. T., Aneurysm of Aorta Treated by Excision: Review of 237 Cases Followed Up To Seven Years, *Am. J. Surgery*, 105:793, 1963.
23. Fleischaker, R. J., Majur, J. H., Baisch, B. F., Surgical Treatment of Acute Traumatic Rupture of the Thoracic Aorta, *J. Thorac. Cardiolvasc. Surg.* 47:289, 1964.
24. DeBakey, M. E., Henly, W. S., Cooley, D. A., Crawford, E. S., Morris, G. C., Jr., Beall, A. C., Jr., Aneurysms of the Aortic Arch: Factors Influencing Operative Risk, *Surg. Clin. N. Amer.* 42:1543, 1962.
25. Engell, H. C., Diagnosis and Surgical Treatment of Aortic Aneurysms, *Acta Chir. Scand.* 128:616, 1964.
26. Rohman, M., Goetz, R. H., State, D., Surgical Treatment of Dissecting Aneurysms of the Aorta with Cardiac Tamponade, *J. Thor. Cardiovas. Surg.* 46:498, 1963.
27. Hume, D. M., Porter, R. R., Acute Dissecting Aortic Aneurysms, *Surgery* 53:122, 1963.
28. Hirst, A. E., Jr., Johns, V. J., Jr., Kime, S. W., Jr., Dissecting Aneurysms of the Aorta: A Review of 505 Cases, *Medicine* 217:37, 1958.
29. DeBakey, M. E., Henly, W. S., Cooley, D. A., Crawford, E. S., Morris, G. C., Jr., Surgical Treatment of Dissecting Aneurysms of the Aorta: Analysis of 72 Cases, *Circulation* 24: 290, 1961.
30. Rob, C. G., Williams, I. P., The Diagnosis of Aneurysm of the Abdominal Aorta, *J. Cardiovasc. Surg.* 2:55, 1961.
31. Edwards, W. S., Arterial Surgery, *G. P.* 30: 104, 1964.
32. Mowitz, D., Dissecting Aneurysm of the Femoral and Popliteal Artery, *Surgery*, 45:834, 1959.
33. Cranley, J. J., Krause, R. J., Strasser, E. S., Hafmer, C. D., Fogarty, T. J., Peripheral Arterial Embolism: Changing Concepts, *Surgery* 55:57, 1964.
34. DeBakey, M. E., Concepts Underlying Surgical Treatment of Cerebrovascular Insufficiency, *Clinical Neurosurgery* 10:310, 1963.
35. Henley, W. S., Cooley, D. A., Gordon, W. B., Jr., DeBakey, M. E., Tortuosity of the Internal Carotid Artery, *Postgrad. Med.* 31:133, 1962.
36. Najafi, H., Javid, H., Dye, W. S., Hunter, J. A., Julian, O. C., Kinked Internal Carotid Artery, *Arch. Surg.* 89:134, 1964.
37. Javid, J., Julian, O. C., Dye, W. S., Hunter,

J. A. Management of Cerebral Arterial Insufficiency Caused by Reversal of Flow, *Arch. Surg.* 90:634, 1965.
38. Parrott, J. C., The Subclavian Steal Syndrome, *Arch. Surg.* 88:661, 1964.
39. Gorman, J. F., Navarri, J. R., McLean, H., Subclavian Steal Syndrome, *Arch. Surg.* 88: 350, 1964.
40. Bernaty, P. E., Necrosis of Colon Following Resection for Abdominal Aortic Aneurysm, *Arch. Surg.* 81:373, 1960.
41. Demos, N., Severe Vascular Impairment of the Left Half of the Colon, *Int. Abstr. Surg.* 117:205, 1963.
42. Laufman, H., Nora, P. F., Mittelpunkt, A. I., Mesenteric Blood Vessels: Advances In Surgery and Physiology, *Arch. Surg.* 88: 1021, 1964.
43. Fry, W. J., Kraft, R. O., Visceral Angina, *Surg., Gynec. Ob.* 117:417, 1963.
44. DeBakey, M. E., Morris, G. C., Jr., Morgen, R. O., Crawford, E. S., Cooley, D. A., Lesions of the Renal Artery, Surgical Technique and Results, *Am. J. Surg.* 107:84, 1964.
45. Intonti, F., Locatelli, E., *Chirurgia* (Milano) 19:1211, 1964.
46. Morris, G. C., Jr., DeBakey, M. E., Cooley, D. A., Crawford, E. S., Experience with 200 Renal Artery Reconstructive Procedures for Hypertension or Renal Failure, *Circulation* 27:346, 1963.
47. Wylie, E. J., Perloff, D., Wellington, J. S., Fibromuscular Hyperplasia of the Renal Arteries, *Ann. Surg.* 156:592, 1952.
48. Stansel, H. C., Jr., Complicated Renal Artery Stenosis, *N. Eng. J. Med.* 270:770, 1964.
49. Poutasse, E. F., Surgical Treatment of Renal Hypertension, *Am. J. Surg.* 107:97, 1964.
50. Stewart, B. H., DeWeese, M. S., Conway, J., Correa, R. J., Renal Hypertension: Appraisal of Diagnostic Studies and of Direct Operative Treatment, *Arch. Surg.* 85:617, 1962.
51. Darling, R., Linton, R. R., Aortoiliofemoral Endarterectomy for Atherosclerotic Occlusive Disease, *Surgery* 55:184, 1964.
52. Hardin, C. A., Survival and Complications in 134 Surgically Treated Cases of Aortoiliac Thrombosis, *Surgery* 55:617, 1964.
53. Cannon, J. A., Kawakami, I. G., Backer, W. F., Present Status of Aortoiliac Endarterectomy for Obliterative Atherosclerosis, *Arch. Surg.* 82:813, 1961.
54. DeBakey, M. E., Crawford, E. S., Garrett, H. E., Cooley, D. A., Occlusive Disease of the Lower Extremities in Patients 16 to 37 years of Age, *Ann. Surg.* 159:873, 1964.
55. Leeds, F. W., Gilfillan, R. S., Importance of Profunda Femoris Artery in Revascularization of Ischemic Limb, *Arch. Surg.* 82:25, 1961.
56. Morris, G. C., Jr., Edwards, W., Cooley, D. A., Crawford, E. S., DeBakey, M. E., surgical Importance of the Profunda Femoris Artery *Arch. Surg.* 82:32, 1961.
57. Louw, J. H., The Treatment of Combined Aortoiliac and Femoropopliteal Occlusive Disease by Splenofemoral and Axillofemoral Bypass Grafts, *Surgery* 55:387, 1964.
58. Gorman, J. F., Douglass, F. M. Axillary-Femoral Artery Bypass, *Arch. Surg.* 91:509, 1965.
59. Vetto, R. M., Dunphy, J. E., Recent Revisions in the Operative Treatment of Vascular Disease, *Surg., Gynec., Ob.* 119:1026, 1964.
60. Wylie, E. J., Binkley, F. M., Albo, R. J., Femoropopliteal Endarterectomy, *Am. J. Surg.* 108:215, 1964.
61. Edwards, W. S., Composite Reconstruction of Small Leg Arteries After Endarterectomy, *Surgery* 51:58, 1962.
62. Hall, K. V., The Thromboendarterectomy as Treatment for Patients with Femoropopliteal Arteriosclerotic Obstruction, *Acta Chir. Scand.* 128:112, 1964.
63. Root, H. D., Cruz, A. B., Jr., Effects of an Arteriovenous Fistula on the Devascularized Limb, *J.A.M.A.* 191:645, 1965.
64. Darling, R. C., Linton, R. R., Management of the Late Failure of Arterial Reconstruction of the Lower Extremities, *N. Eng. J. Med.* 270: 609, 1964.
65. DeBakey, M. E., Crawford, E. S., Morris, G. C., Jr., Cooley, D. A., Garrett, H. E., Late Results of Vascular Surgery in the Treatment of Arteriosclerosis, *J. Cardiovasc. Surg.* 5: 473, 1964.
66. Spencer, F. C., Rienhoff, W. F., Reconstructive Surgery for Occlusive Disease of Femoral and Popliteal Arteries, *Surgery* 54: 709, 1963.
67. Szilagyi, D. E., Smith, R. F., Elliott, J. P., Venous Autografts in Femoropopliteal Arterioplasty, *Arch. Surg.* 89:113, 1964.
68. Dotter, C. T., Judkins, M. P., Transluminal Treatment of Arteriosclerotic Obstruction, *Circulation* 30:654, 1964.

"THE LIGHT HERE KINDLED"

THE STORY OF OAK FOREST HOSPITAL

Beth Fonda

An old aphorism holds that a man's character is what he actually is—his reputation is what others think he is. The character of the 54-year-old Oak Forest Hospital of Cook County in Illinois is that of an accredited hospital for the care of the chronically ill. Unhappily, its outmoded reputation as a poorhouse persists in many quarters, a misapprehension shared by professional and nonprofessional people alike.

The hospital, located at 159th and Cicero Avenues in southwestern Cook County, is a modern, well-equipped, competently staffed hospital for medical and surgical as well as domiciliary care of 2400 chronically ill patients, 53 percent of whom are older than 60 years. The hospital operates under the jurisdiction of the Board of Commissioners of Cook County.

Long gone are the days of overcrowding and understaffing, of tuberculous and psychotic patients, often referred to as "inmates" or "pogies," often poorly nourished, certainly neglected and left to vegetate in hopeless apathy.

The Old Oak Forest Infirmary

Eugene J. Chesrow, M.D., Medical Superintendent since 1940, is possessed of a dynamic optimism and a capacity for inspiring enthusiasm which must surely have been a prime factor in achieving the upgrading of the hospital in recent years. In 1962, he reported to the National Geriatrics Society: "In order to properly evaluate the progressive transformation at Oak Forest Hospital, one should be reminded of conditions as they existed just prior to World War II. It was known for years as the 'poorhouse' and the 'county farm.' It was not uncommon to house as many as 5,000 patients during the fall and winter, but seldom less than 3,500 during clement weather. In addition, Oak Forest cared for some 700 patients suffering from advanced and far advanced pulmonary tuberculosis. These were 'hospitalized' in several different buildings and cottages. Closed wards housed nearly 400 mentally ill patients. A small infirmary hospital section cared for the more seriously ill. A very common phrase prevailing at that time was 'over the hill to the poorhouse.' It was a place to go and die. Particular sections were known by such names as the 'irresponsible wards' or the 'incontinent dormitories.' One of the buildings housing tuberculous patients was characterized as 'Death Valley.' It was not uncommon for many dormitory-like wards with a maximum normal capacity of 40 patients to house as many as 60 or more."

During that period, ten underpaid physicians, working ten hours daily, six days a week, comprised the entire medical staff. A small group of visiting physicians, pos-

sibly one or two board certified, were available for consultation. A handful of professional nurses and some 150 aides attempted to care for 5,000 patients.

Laboratory facilities consisted of a small, ill-equipped area in the infirmary and a similar one in the tuberculosis hospital, under the supervision of a technician with only practical training. Operating room equipment was virtually lacking. Almost all housekeeping and janitorial services were performed by patients. Food kitchens for both the infirmary and the tuberculosis hospital were supervised by one dietitian. Patient help was commandeered, and accidents were frequent.

The New Oak Forest Hospital

What has happened since then? In the last few years, vision and hard work, elbow grease and prayer have brought Oak Forest up from a place of darkness and death to an institution for the care of the chronically ill of which Cook County and Illinois can be justifiably proud. Our geriatric population continues to expand tremendously, and both the private physician and the community recognize an increasing responsibility for the mental and physical health of the aging, often economically deprived patient. Oak Forest Hospital as it is today might well serve as a model for similar longterm care facilities in any community.

The battle of the limited budget versus limitless needs is not over at Oak Forest—but encouraging strides have been made. A member of the consulting staff had this to say: "There are areas at the hospital that need improvement. No one denies that. But the point is, they never stop trying. They are never content with things as they are."

A neuropsychiatrist, a full-time staff member, puts it this way: "Medical men in all fields are aware of the steady growth of our geriatric population. More physicians are needed in the practice of gerontology. Here we are trying to treat the whole person, not the dependent, chronically ill 'case,' often unwanted by the family he has left."

The old "poorhouse" now has eight miles of wide, clean corridors in a complex of 60 interconnected buildings. Wards are well lighted and spotless. Privacy is maintained through a cubicle setup. Buildings are ramped inside and out for easy wheelchair passage, and maintained at a uniform temperature. A few private rooms are reserved for critically ill patients, or those requiring isolation. Laboratory facilities, modernized operating rooms, diet kitchens, roentgenographic, electroencephalographic and electromyographic equipment equal those found in the best of modern geriatric facilities. Prepared under the supervision of trained professional dietitians, the food is good, nourishing and served hot from a number of auxiliary kitchens throughout the hospital. A Kosher kitchen is operated according to strict dietary laws.

Protestant, Catholic and Jewish chapels serve patients and staff. Television rooms throughout the hospital afford patients hours of pleasure. Grassy sunning areas, easily accessible to ambulatory and wheelchair patients, are favorite gathering places in warm weather, when music is piped outdoors. The hospital has available both beauticians and barbers.

An elderly arthritic wheelchair patient was enthusiastic. "There's always something to do here. You don't have a chance to feel lonely or forgotten. We have movies two nights a week, and a fun and frolic session one night when some of the patients entertain, and we have coffee and cupcakes. Sometimes retired men come and play bingo with the men here, or write letters, or just visit. I'm happier than in my granddaughter's house, and the doctors have done a lot for my pain."

Patient morale generally is high. The listless apathy so often seen in facilities for care of the aged and ill, or the chilly, if efficient, impersonality of the large institution is nowhere in evidence at Oak Forest Hospital.

Staff, Facilities, and Equipment

The character of the patient population has altered since 1940. First, the mentally ill were transferred to mental hospitals through the Cook County Mental Health Clinic. The tuberculosis hospital was closed and completely renovated. More beds were made available through an extensive rehabilitation program and a 250-bed addition was completed in 1960. The huge dormitories were modernized and converted into small wards. Special wards were set

up for intensive medical and nursing care of patients with diabetes, cardiovascular, or neurologic disorders. Two surgical wards were equipped for any contingency. A modern residence for nurses was built. Oak Forest has an approved school for practical nurses and a training program for aides.

The permanent staff now numbers forty-one physicians who have made a full-time specialty of geriatric medicine. A rotating residency program in internal medicine, urology, ophthalmology, pathology and roentgenology functions with the cooperation of Cook County Hospital. Service schedules are rotated every six months.

High Attendance at Staff Meetings

Attendance at monthly staff meetings and clinical and pathologic conferences averages between 80 and 85 percent. The staff participates in the work of such committees as medical records, patient discharge and planning, pharmacy, infections, tissue, staff library and surgical morbidity and mortality. As part of the teaching program, the resident staff is supervised by members of the consulting staff, the Oak Forest Director of Medical Education, the Director of Medical Education of Cook County Hospital, and the Director of the Department of Pathology for all Cook County institutions.

Twenty-one physicians, specialists in their respective fields, compose the consultant staff. The men are certified in internal medicine, orthopedics, urology, surgery, ophthalmology, neuropsychiatry, and dermatology. Consultants spend not less than one half day once to three times weekly at the hospital, and as part of the teaching program, hold one or two clinical conferences monthly. Oak Forest is the first institution of its kind to make available annually its collected papers in book form.

The Department of Pathology and Clinical Laboratories comprises pathologic anatomy, surgical pathology, and cytology, as well as subsections of biochemistry, hematology, and microbiology. Equipment, including a Coulter counter, dark field apparatus, and an autoanalyzer, is up to date. Laboratory personnel are exceptionally well qualified. Clinical pathologic conferences are conducted weekly. Approximately 85,000 determinations are done annually. Oak Forest laboratories have an A rating from the American Medical Association.

In 1963-1964, the autopsy percentage was 24.1. Recorded postmortem findings are an illuminating component of research concerning cause of death in the aged patient who more frequently than not has multiple disease entities.

In a whole blood depository, 25 to 30 pints of blood are constantly on hand, typed and cross-matched according to National Institutes of Health standards.

During 1964, the Department of Roentgenology processed 12,000 films involving 9,000 patients. A chest roentgenogram is mandatory for all new admissions, and all patients and personnel have an annual chest film. Technicians at Oak Forest are ingenious in devising methods of obtaining good films in patients whose physical disabilities, deformities, or indwelling catheters render accurate positioning difficult. Full-time supervision is provided by three consultants. Maximum safety is assured by constant radiation monitoring service.

Oak Forest Hospital has a pulmonary functions laboratory, and electroencephalographic and electromyographic equipment, as well as electroeardiographic and BMR apparatus.

Department of Health is Involved

A Department of Health Service and Emergency First Aid maintains a constant check on the health of hospital personnel, and implements a thorough immunization program for both patients and employees. The Outpatient Clinic, open five days weekly, serves persons on public assistance and other medically indigent persons in south and southwest Cook County. A dermatologic clinic in the outpatient building functions under the direetion of two consulting dermatologists.

Dental care, including emergency bedside treatment, and a complete dental survey of all newly admitted patients is provided by the Dental Service. Dentures are provided or repaired when necessary.

In the Medical Records Department, coding and processing of diagnostic information is handled through a punch card system. In the offing is microfilm equipment for storage and retrieval of medical records.

Examination and treatment of hearing and visual disturbances are an important segment of geriatric medicine. Many patients require surgery for correction of cataracts. Hearing aids and glasses are fitted as necessary.

Each new patient is thoroughly evaluated by the staff of the Department of Neuropsychiatry and Clinical Psychology, under the direction of a full-time neuropsychiatrist. In addition to diagnostic and therapeutic measures, staff members render neuropsychiatric assistance to personnel and limited psychotherapy to those in need of this service. Lectures on neurologic and psychiatric problems to the medical and nursing staffs are frequent and well attended.

Under the supervision of a full-time clinical psychologist, the Department of Clinical Psychology renders diagnostic and therapeutic as well as vocational and educational services. The department has for some years been engaged in extensive research concerning the neurologic effects of chronic alcoholism. The permanent staff includes a vocational psychologist, a rehabilitation psychologist, a speech pathologist, a corrective speech therapist, and a laboratory technician. Treatment of aphasic patients is a vital part of the work in a population with a high incidence of neurologic residuals resulting from cerebrovascular accidents.

Nursing Care

Probably one of the primary factors in the preeminence of Oak Forest Hospital as a long-term care facility is the quality of the nursing care. A consultant in internal medicine says, "Good nursing care is invaluable in these old, chronically ill people who are subject to a variety of degenerative processes. Attentive nursing care is probably the first line of defense in controlling these. The care at Oak Forest is as good as the best available, and better than that in most private nursing homes I have seen. No decubiti develop here. Patients often come in with them, but they don't develop at Oak Forest, largely because of intensive nursing care."

On admission to Oak Forest Hospital, the patient has a complete and thorough physical examination. The majority of the elderly patients require intensive treatment for physiologic or mental disability, or both. In addition to neuropsychiatric assessment, ophthalmologic examination, dental survey, and evaluation by the Department of Physical Rehabilitation, a chest roentgenogram, electrocardiogram, and complete blood and urine studies are made. Referral to Medical Social Service may seem advisable if there are urgent personal or family problems. From the beginning, emphasis is twofold—on the physical well-being of the patient, and on his emotional and mental health and social adjustment in a new setting.

Patient Independence Is Goal

Foremost among the goals of staff and administration is to assist each patient to achieve the maximum physical independence and emotional tranquility possible within the limits of his disability. Each component of an individual regimen is designed to encourage attainment of full potential capacity. This may range from restored ability to feed himself and care for his personal needs, to the acquisition or restoration of skills which may eventually permit return to community life. Attention is focused on the total person, not upon the disease entity alone.

Psychiatric evaluation may indicate that a patient will derive benefit from group therapy sessions. He will be referred for speech therapy if he is aphasic. Physical therapy will be prescribed for the hemiplegic patient. Artificial eye or extremity prostheses may be required, or a denture badly needed. Through interdepartmental consultation, a program is worked out to insure that some or all of the multiple facilities of the hospital will be marshalled to provide the indicated therapy, physical, neuropsychiatric, social, or all three. As many services as possible are brought to a bedridden patient.

The Director of the Department of Physical Rehabilitation believes that with these elderly patients, hope and motivation are everything. "The patient must be encouraged to reach his maximum capacity. We show him how, and let him do it. Always let him do it if he can—and usually, with patience, he can. We are never hard, or unfeeling, but we try not to make the mistake of doing things *for* the patient

when his real salvation lies in regaining the ability to do things for himself and by himself. We never say die—we say TRY, and then try some more and then try a little harder. Why let them vegetate?''

Occupational therapy plays an essential role in return of lost function and increased dexterity. Depending upon individual needs and goals, patients work with leather, looms, typing, painting, jewelry making, woodshop, with tasks graded in difficulty as manual function improves. Handicraft products are sold in a shop in the hospital, with proceeds going to buy materials used.

Oak Forest Hospital is not a charity institution. Patients who are able are expected to pay a moderate monthly charge. Because need in Cook County outstrips available facilities, a waiting period of several months is usually necessary after referral by a physician.

"The Light Here Kindled"

Over an archway at the entrance to an occupational therapy room at Oak Forest Hospital of Cook County appears this quotation: ''Count that day lost in which you do not do at least one thing for others, for which you are not paid.''

It would be difficult to measure in terms of material pay the triumph and fulfillment experienced by both staff and fellow patients when a young man, a quadriplegic able to use only the strong muscles of neck and jaws, renders a creditable copy of Gainsborough's Blue Boy, with the paint brush held in his teeth. Or the gratified smile lighting up the face of a severely aphasic patient who has succeeded in uttering his first completely intelligible phrase after weeks of painstaking efforts following a stroke. Behind those achievements lie months of slow, determined effort by the patient and by the physicians and therapists.

Perhaps the greatest therapeutic tool in constant use at Oak Forest is the genuine, unflagging interest in each and every patient displayed by professional staff and personnel alike. More than the new buildings, the modern laboratories and equipment, the efficient diet kitchens, and all the other prerequisites of any fine hospital, it may be this quality that distinguishes the old Oak Forest from the new, and accounts for the tangible spirit of cheerfulness that pervades the wards.

One of the most dedicated of the staff physicians observed, ''These old people often need most of all just someone to talk to—someone who really listens, someone who cares.''

Everyone cares at Oak Forest Hospital.

SIDE EFFECTS--TRUE OR FALSE?

The (FDA) adverse reaction program is off to a fair start and should get better, but concentration on side effects has put too much information into the hands of the laity and the uninformed, who tend to misinterpret. As a consequence, more side effects are being reported now that aren't really side effects, but rather the imaginations of those who got their hands on medical advertising or package inserts. It is the duty of the manufacturers to provide all the information to the physician about the drugs they make. All side effects should be clearly spelled out for him, but they should not be emphasized over and above the therapeutic activity.—Robert W. Ballard, M.D., *Food Drug Cosmetic Law Journal,* January 1966.

THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

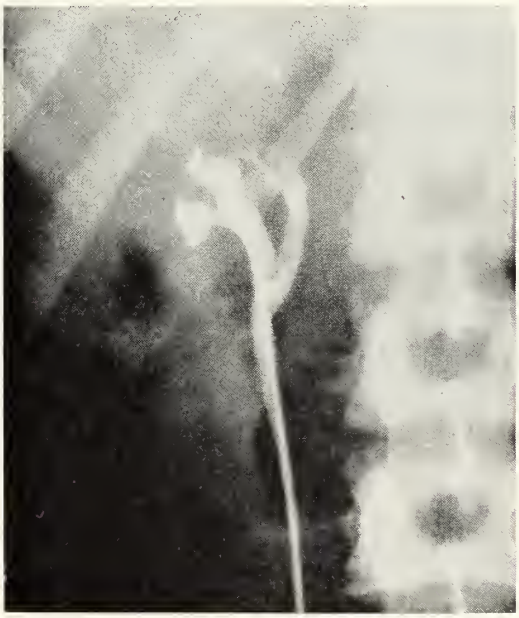


Figure 1

This 13-year-old female entered Cook County Hospital with a history of repeated attacks of right flank pain for five years. She had been operated on six months previously in a hospital in Mississippi; the surgical procedure was described as a pyeloplasty and ligation of an aberrant renal artery.

Examination of the urine revealed 2+ albumin with many WBC's. An I.V.P. revealed extremely faint function on the right. A right retrograde was done. (Figure 1)

What is your diagnosis?

(answer on next page)

(continued)

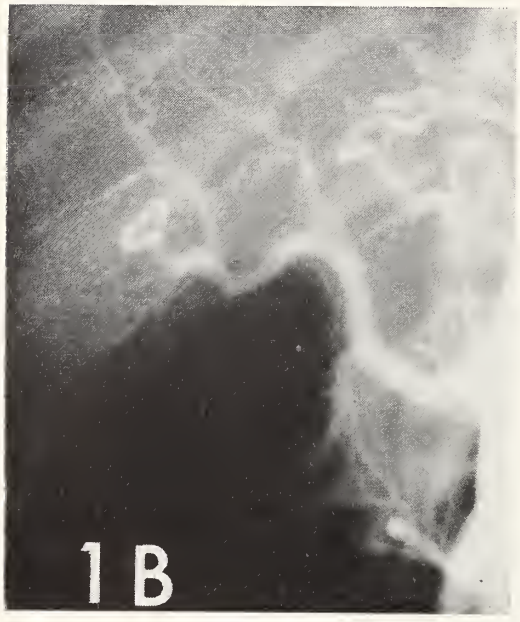


Figure 2



Figure 3

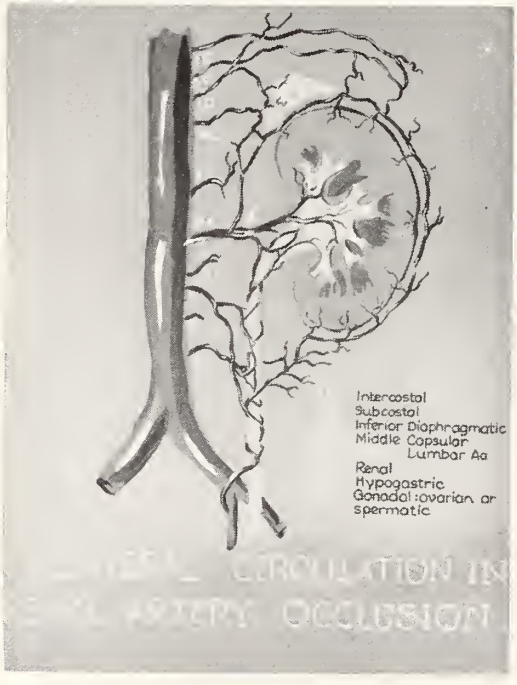


Figure 4

Diagnosis: Surgical ligation of the renal artery with infarction of the kidney.

An aortogram was done and 40 cc. of sodium iothalamate 66.8% was injected through a catheter. The right renal artery is occluded about one inch from its origin. (Figure 2) The large branching vessel seen above is the hepatic artery arising from the coelic axis.

Figure 3 demonstrates an attempt at collateral circulation to bypass the occluded renal artery. The small amount of function in the kidney is accounted for by the collateral vessels which arise from the intercostal, capsular and ureteral vessels. (Figure 4)

At surgery, a surgical tie was found about one inch distal to the origin of the right renal artery. A nephrectomy was done and pathology reported renal infarction with associated chronic pyelonephritis.

Reference

Abrams, Herbert L. and Cornell, Steven H.: Patterns of collateral flow in renal ischemia. *Radiology* 84:1001-1012, June 1965.



THE FOOT IS IN THE DOOR

One of the major objections to Medicare prior to the passage of P.L. 89-97 was that it might provide our Federal government with a program that could be expanded overnight into total socialized medicine. At the present time the plan covers those 65 years and over but the age limits could be lowered to 60, than 50 and finally to include all living Americans. Law makers usually close their eyes and ears to anything that might happen in the years to come, and find it expedient to reply "that is not what we are voting on today," or "what the Senate does 10 years from now is none of my business."

Arthur J. Altmeyer, one of the founders of the Social Security system has already begun to push for a greatly expanded system including Medicare for all Americans. This was done in a recent Washington speech and there is reason to believe that those who share this philosphy will beat the bushes harder than ever before. Their foot is in the door and we can expect the big push at anytime.

T. R. Van Dellen, M.D.

FIXED HEART RATES IN INFANTS WITH IDIOPATHIC RESPIRATORY DISTRESS SYNDROME

An important clinical finding in infants with idiopathic respiratory distress syndrome is that during the height of the infant's respiratory distress the heart rate becomes fixed at between 110 to 120 beats per minute.[1] The heart rate in these cases did not vary if the infant cried or was stimulated to physical activity. If the infant survived one of the early signs of improvement was an increase in the heart rate to 140-150 per minute. The heart rate then became more labile and responsive to stimulation. Doctors A. J. Rudolph, C. Vallbova and M. Desmond employed a new technique for monitoring heart rates in the neonate which accurately recorded the number, duration and amplitude of the instantaneous heart rate.[2] Their results showed that the fixation of the heart rate was present in 50.3% of the 74 premature infants with respiratory distress. It was found most frequently in the first 24 hours

after birth. Dr. Rudolph's group confirmed the observations of Burnard that the fixation of the heart rate in an infant with idiopathic respiratory distress syndrome is indicative of a poor prognosis.

In a second study of the heart rate of premature infants who were free of respiratory distress syndrome. Rudolph and his co-workers found that the majority of the cases showed fluctuations in the cardiac rate.

Rudolph and his group believe that the fixation of the heart rate in the respiratory distress syndrome suggests that a dysfunction of the medullary center of the brain may occur as part of the syndrome. They cite a number of references suggesting a link between the idiopathic respiratory distress syndrome and immaturity or injury to the central nervous system.

These important findings illustrate the complexities involved in the problems of unraveling the cause of the idiopathic respiratory distress syndrome.

Harvey Kravitz, M.D.

References

1. Burnard, E. D. Changes in heart size in the dyspneic baby. *Brit. Med. J.* 1:1495, 1959.
2. Rudolph, A. J., Vallbova., and Desmond, M. M. Cardiodynamic studies in the newborn III. Heart rate patterns in infants with idiopathic respiratory distress syndrome. 36:551, 1965.

NEW TYPHOID VACCINE

According to the "Medical Letter," the U. S. Public Health Service is considering a change in the standard of typhoid vaccination. The new product will contain only killed typhoid organisms; killed paratyphoid will be omitted because the effectiveness of their antigens has not been established and the paratyphoid organisms increase the severity of reactions to the vaccine.

Recent typhoid epidemics in Scotland and Switzerland demonstrate that no area is free of the risk of this disease and the vaccine should be recommended to all persons planning trips to foreign countries.

T. R. Van Dellen, M.D.

PAST SMOKERS' SYNDROME

The smoke-filled room annoys many non- and past smokers in much the same way as the inhabitants of Los Angeles are bothered by smog. The odor of the polluted air is distasteful to them and the majority get a second whiff when they get home and remove their clothing which reeks of smoke. In addition, the eyes water and the nose becomes congested. It is difficult to concentrate on the subject of the meeting.

We have dubbed the condition past smokers' syndrome, because those who quit smoking are most likely to be bothered. It is difficult to explain why this did not occur to them while they were smoking, except perhaps they were so saturated with nicotine that they could not smell "the tree for the forest." There is no doubt that smoking dulls the sense of smell and taste. As a heavy smoker of many years' duration who quit 17 years ago, I cannot believe that the odor of smoke is disagreeable for psychological reasons—namely, jealousy.

We know now why railroads set aside a car for smokers. Our only solution—outside of insisting on no smoking at meetings—is to require smokers to sit on the side of the room where the exhaust fans or vents are located. In this way the exhaled smoke will not flow across the faces of the non-smokers.

Cigarette smokers will disagree and insist that it is up to the non-smokers to find a seat that is not likely to be surrounded by polluted air. We'll buy this provided a sign or arrow is posted to indicate the direction of the air currents.

Smokers versus non-smokers is a controversy that will continue ad infinitum.

T. R. Van Dellen, M.D.

DELEGATES' HANDBOOK

ILLINOIS STATE MEDICAL SOCIETY

126TH ANNUAL CONVENTION

SHERMAN HOUSE CHICAGO

MAY 15-18, 1966



INDEX

HOUSE OF DELEGATES

Agenda 366
Committees 368
Members 363

REPORTS OF OFFICERS AND TRUSTEES

President 371
President-Elect 372
First Vice President 373
Second Vice President 373
Secretary 374
Speaker and Vice Speaker 381
Trustee Reports
- First District 374
- Second District 375
- Third District 375
- Fourth District 375
- Fifth District 376
- Sixth District 376
- Seventh District 377
- Eighth District 377
- Ninth District 378
- Tenth District 379
- Eleventh District 380

SPECIAL REPORTS

Advisory Committee to the Woman's Auxiliary 383
Chairman, Board of Trustees 383
Committee to Study Committees 392
Ethical Relations Committee 393
Illinois Department of Mental Health 389
Illinois Department of Public Aid 388
Illinois Department of Public Health 387
Illinois Division of Vocational Rehabilitation 390
Membership Committee 394
Policy Committee 391
President, Woman's Auxiliary 382

ADMINISTRATIVE REPORTS

AMA Delegation, 1966 405
Archives Committee 403
Benevolence Committee 405
Educational & Scientific Foundation 407
Executive Administrator 400
Medical Student Loan Fund Committee 403
Secretary-Treasurer 395

CONSTITUTION AND BYLAWS

Committee on Constitution and Bylaws 407

ECONOMICS AND INSURANCE

Aging 410
Blue Cross-Blue Shield Liaison 414
Drug Manual 413
Fee Schedules 419
Hospital Relations 418
Medical Advisory Committee to the Illinois Department of Public Aid 411
Medical Economics 417
Prepayment Plans and Organizations 414
Rehabilitation Services 413
Relative Value 414
Usual and Customary Fees 420

LEGISLATION AND PUBLIC AFFAIRS

Department of Registration and Education, Liaison 432
Impartial Medical Testimony 430
Laboratory Evaluation 433
Legislative 422
Medical-Legal 430
Narcotics and Hazardous Substances 434
Occupational Health 432
Public Affairs 428
Quackery 432

MISCELLANEOUS BUSINESS

Illinois Association of Professions 436
Illinois Osteopathic Association, Liaison 435
Interprofessional Council, Liaison 437
Medical Advisory Committee to Selective Service 436
Pharmaceutical Association, Liaison 435

PUBLICATIONS AND SCIENTIFIC SERVICES

Cancer Control 442
Cardiovascular Disease 442
Child Health 442
Committee to Study Convention 441
Continuing Education 443
Editor, Illinois Medical Journal 440
Editorial Board 438
Environmental Health 444
Eye Health 446
Maternal Welfare 446
Medical Education 447
Mental Health 449
Nursing 450
Nutrition 450
Perinatal Mortality 450
Radiation 451
Scientific Assembly 440
Scientific Exhibits 441
Special Problems of Medical Education 449
Standard Vital Certificates 453
Tuberculosis 451

PUBLIC RELATIONS

Advisory Committee to the Health Careers Council of Illinois 460
Advisory Committee to the Illinois Medical Assistants Association 459
Advisory Committee to the Student American Medical Association 462
Disaster Medical Care 461
Fifty Year Club 460
Grievance 460
Medicine and Religion 463
Physicians Placement Service 457
Public Relations 454
Public Safety 458

RESOLUTIONS 464

Members of the 1966 House of Delegates

OFFICERS

President.....Burtis E. Montgomery
President Elect.....Caesar Portes
1st Vice President.....Michael R. Saxon
2nd Vice President.....Casper Epsteen
Secretary-Treasurer.....Jacob E. Reisch
Speaker.....Edward W. Cannady
Vice Speaker.....Maurice M. Hoeltgen

BOARD OF TRUSTEES

First District.....Carl E. Clark
Second District.....Ralph N. Redmond
Third District.....William M. Lees, Frank J. Jirka, Philip G. Thomsen, J. Ernest Breed, William E. Adams, Ted LeBoy
Fourth District.....Paul P. Youngberg
Fifth District.....Darrell H. Trumpe
Sixth District.....Newton DuPuy
Seventh District.....Arthur F. Goodyear
Eighth District.....William H. Schowengerdt
Ninth District.....Charles K. Wells
Tenth District.....Willard C. Scrivner
Eleventh District.....Joseph R. O'Donnell
Trustee-at-large.....Edward A. Piszczek

PAST PRESIDENTS

Everett P. Coleman.....1945-1946
Harlan English.....1964
Rolland L. Green.....1937
Edwin S. Hamilton.....1962
H. Close Hesseltine.....1961
Percy E. Hopkins.....1949
James H. Hutton.....1940
Willis I. Lewis.....1954
George F. Lull.....1963
Irving H. Neece.....1948
Raleigh C. Oldfield.....1959
Leo P. A. Sweeney.....1953
Arkell M. Vaughn.....1955
C. Paul White.....1952

OFFICERS OF AMA

Percy E. Hopkins (duplicate-Past President)
Chairman—Board of Trustees, AMA
Walter C. Bornemeier (duplicate-
Vice Speaker, House of Delegates, AMA)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Walter C. Bornemeier (duplicate-AMA Officer)
E. W. Cannady—(duplicate-Speaker)
Harlan English—Past President
William K. Ford
Frank H. Fowler
Arthur F. Goodyear—(duplicate-Trustee)
H. Close Hesseltine—(duplicate-Past President)
Maurice M. Hoeltgen—(duplicate-Vice Speaker)
B. E. Montgomery—(duplicate-President)
H. Kenneth Scatliff
Leo P. A. Sweeney—(duplicate-Past President)

CHICAGO MEDICAL SOCIETY DELEGATES AND ALTERNATES

Aux Plaines Branch

Delegates	*Alternates*
John S. Hyde	Robert F. Sharer
C. Otis Smith	Everett E. Nicholas
Herbert Ratner	James B. Hartney
Charles J. Weigel	Michael J. Parenti
Arthur E. Joslyn, Sr.	A. Everett Joslyn, Jr.
Arthur Gene Lawrence	Roland Kowal
Joseph C. Sodaro	William F. Ashley
Clair M. Carey	Craig D. Butler

Calumet Branch

Donald F. Farmer	Chas. E. Corcoran, Jr.
Stanley E. Ruzich	Harry F. Weisberg
Thaddeus C. Fial	Eugene F. Diamond

Douglas Park Branch

Edward A. Razim	Otto Koluvek, Jr.
Colman J. O'Neil	Robert F. Cesafsky
L. S. Tichy	Paul Zettas
John D. McCarthy	Gilbert R. DeMange
Raymond Nemecek	Miles Cermak

Englewood Branch

Marcello Gino	Samuel L. Hamilton
Edward J. Krol	John R. Krolikowski
Frank C. Kwinn	John E. Meyer
Frank J. Saletta	Joseph A. Patka
Francis W. Young	George J. Rukstinat

North Suburban Branch

Arnold Wagner	Stanley E. Huff
William Cummings	Robert P. Cutler
Frank Pirruccello	Martin M. Fahey
Raymond H. Conley	Jerome T. Paul
David R. Barnum	Billy D. Reeves
Harold Lueth	Howard C. Burkhead
C. Malcolm Rice, Jr.	James W. Ford

Delegates	*Alternates*
John L. Savage	Donald E. Hansen
William Harridge	William J. FitzPatrick
Irving Park Suburban Branch	
George W. Holmes	Arnold U. Derman
Fred A. Tworoger	S. A. Franzblau
David O. Dale	Eugene T. Broccolo
Eugene M. Narsete	H. Paul Carstens
Alexander N. Ruggie	Allen Hrejsa
George C. Turner	Justin Fleishmann
Arthur Haebich	F. J. Haufe
T. J. Conley	Philip Heller
Alfred Faber	Martin Meisenheimer
Jackson Park Branch	
Wright R. Adams	Julius Ginsberg
Andrew J. Brislen	Chester Guy
William J. Hand	H. Herbolsheimer
David S. Fox	Harry L. Hunter
Loran Dill	Daniel J. Pachman
Charles P. McCartney	Myron M. Hipskind
North Shore Branch	
Chester L. Crean	Willis J. Diffenbaugh
Philip R. McGuire	Robert Jensik
Edward C. Helfers	Eugene J. Ranke
W. B. Stromberg, Sr.	John B. Murphy
*Karl L. Vehe	Samuel T. Gerber
Joseph R. DeCaro	Frank M. Quinn
W. O. Ackley	David T. Petty
Philip M. Bedessem	George C. Markoutsas
George H. Irwin	Rocco V. Lobraico
Burton Soboroff	Herschel Browns
C. A. Norberg	Joseph Skom
North Side Branch	
Vincent Freda	Harold Lasky
Jack Williams	Benjamin Lounsbury
Erwin M. Patlak	Gustav Kaufmann
Clifton L. Reeder	Steven Barron
John Malia	James P. FitzGibbons
Michael Boley	Joseph Sherrick
Roland R. Cross	R. Gilchrist
Samuel L. Andelman	Carl Hedberg
William Hutchison	Bernard Peele
Coye C. Mason	Marvin Rosner
Northwest Branch	
S. M. Goldberger	Chester Podgorski
Richard V. Kochanski	A. Rynarowich
N. J. Kupferberg	M. A. Rydelski
Michael J. Kutza	J. M. Smialek
I. P. Lombardo	Louis A. Wajay
Alfred A. Zanette	*Emil R. Zidek
South Chicago Branch	
John M. Coleman	Wm. J. Marshall, Jr.
Morris T. Friedell	John A. Caserta
Francis P. Malloy	Maynard I. Shapiro
Simon Y. Saltman	Albert Pisani
South Side Brnach	
Alfred S. Klinger	Solomon Green

* Deceased

Delegates	*Alternates*
Quentin Young	Jacob Epstein
Robert R. Mustell	Maurice Gleason
Southern Cook County Branch	
Frederick Weiss	John Koenig
Howard W. Schneider	Leonard Lewis
Cyril Gallati	Gerard Gnade
Stock Yards Branch	
Edwin J. Lukaszewski	Joseph M. Ruda
Glenn A. Burckart	Frank J. Nowak
West Side Branch	
George Kaiser	Eugene T. Hoban
Anna Marcus	George Rezek
Joseph F. O'Malley	Louis S. Varzino
At-Large	
Casper M. Epsteen	Harold A. Sofield
Allison L. Burdick, Sr.	Noel G. Shaw

DOWNSTATE DELEGATES AND ALTERNATES

County	*Delegate*	*Alternate*
Adams County—6th District		
	James R. Cooper	Harold Swanberg
Alexander County—10th District		
	James L. Crouse	Fay S. Comer
Bond County—7th District		
	Boyd E. McCracken	Charles R. Daisy
Boone County—1st District		
	John H. Steinkamp	M. Paul Dommers
Bureau County—2nd District		
	George E. Giffin	Louis Lukancic
Carroll County—1st District		
	L. B. Hussey	B. V. Gunnarsson
Cass-Brown County—6th District		
	B. A. DeSulis	James J. Hea
Champaign County—8th District		
	C. H. Walton	H. J. Kolb
	Richard E. Schaede	D. G. Rumer
Christian County—7th District		
	C. D. Brummitt	Ralph M. Seaton
Clark County—8th District		
	Eugene P. Johnson	George T. Mitchell
Clay County—7th District		
	H. D. Fehrenbacher	L. L. Hutchens
Clinton County—7th District		
	Wilson L. DuComb	Francis H. Ketterer
Coles-Cumberland County—8th District		
	Joseph R. Mallory	Mack W. Hollowell
Crawford County—8th District		
	Charles N. Salesman	John W. Long
DeKalb County—1st District		
	T. P. deGraffenried	John W. Ovitz, Jr.

County	*Delegate*	*Alternate*
DeWitt County—5th District		
	George Castrovillo	H. L. Meltzer
Douglas County—8th District		
	Ervin Gross	Walter G. Steiner
Du Page County—11th District		
	William E. Hill	Charles B. Van Gorder
	Morgan Meyer	Arthur P. LeBeau
	James P. Campbell	F. C. Kuharich
	J. P. Schweitzer	B. L. Rodkinson
Edgar County—8th District		
	J. M. Ingalls	J. A. Acklin
Edwards County—9th District		
	Charles P. Salisbury	Andrew Krajec
Effingham County—7th District		
	Peter C. Rumore	Wm. C. Van Burgen
Fayette County—7th District		
	S. W. Moore	J. H. Weiner
Ford County—11th District		
	Paul Sunderland	Ross Hutchison
Franklin County—9th District		
	John P. Pope	H. L. Lewis
Fulton County—4th District		
	K. H. Frankhauser	Paul D. Reinertsen
Gallatin County—9th District		
	John E. Doyle	W. F. Stanelle
Greene County—6th District		
	Paul A. Dailey	A. K. Baldwin
Hancock County—4th District		
	C. W. Bruehsel	Byron E. Mueller
Henderson County—4th District		
	Silvino Lindo, Jr.	Elmer Swann
Henry-Stark County—4th District		
	Paul M. Schmidt	William D. Larson
Iroquois County—11th District		
	R. Kent Swedlund	James E. Dailey
Jackson County—10th District		
	Joseph A. Petrazio	Martin Van Brown
Jasper County—8th District		
	Don L. Hartrick	C. O. Absher
Jefferson-Hamilton County—9th District		
	Herman Rogers	A. W. Anderson
Jersey County—6th District		
	William Clark Doak	
Jo Daviess County—1st District		
	R. David Holmsten	C. George Ward
Johnson County—9th District		
	E. A. Veach	
Kane County—1st District		
	Wayne N. Leimbach	William H. Donovan
	B. F. Shirer	J. L. Bordenave
	John A. Newkirk	D. W. Schleifer
Kankakee County—11th District		
	Dale M. Learned	Deland J. Burns
Kendall County—11th District		
	Victor Smith	Ray Crawford
Knox County—4th District		
	Fred Stansbury	Richard H. Bick
Lake County—1st District		
	Donald C. Nellins	Walter J. Reedy
	M. J. McAndrew	John Andrews
	Charles U. Culmer	Kenneth Morris
La Salle County—2nd District		
	William Scanlon	James B. Aplington
Lawrence County—8th District		
	Gilbert Miller	Tom Kirkwood
Lee County—2nd District		
	Wm. A. McNichols	Charles H. LeSage
Livingston County—2nd District		
	Don L. Ervin	George T. Crout
Logan County—5th District		
	Wayne Schall	Charles Bardwell
McDonough County—4th District		
	Donald H. Dexter	V. Burdette Adams
McHenry County—1st District		
	M. Mijanovich	A. Mijanovich
McLean County—5th District		
	L. T. Fruin	A. Edward Livingston
Macon County—7th District		
	Maurice D. Murfin	C. F. Downing
	C. Elliott Bell	H. J. Burstein
Macoupin County—6th District		
	Joseph J. Grandone	Howard A. Finney
Madison County—6th District		
	E. K. DuVivier	James Adams
	M. Pfeiffenberger	W. W. Bowers
Marion County—7th District		
	Karl D. Venters	Harry D. Nesmith
Mason County—5th District		
	Jack Means	Dario Landazuri
Massac County—9th District		
	George Green	Enrique T. Yap
Menard County—5th District		
	Paul L. Purdy	Barry D. Free

County	*Delegate*	*Alternate*
Mercer County—4th District		
	John E. Bohan	Martin E. Conway
Monroe County—10th District		
	Joseph Werth	F. W. Gebhardt
Montgomery County—5th District		
	George A. Telfer	Ernest Frank
Morgan County—6th District		
	A. F. Fricke	Robert R. Hartman
Moultrie County—7th District		
Ogle County—1st District		
	Russel W. Zach	A. R. Bogue
Peoria County—4th District		
	Wm. O. McQuiston	G. W. Giebelhausen
	Norman Powers	S. M. Scalzo
	Fred Z. White	George J. Best
Perry County—10th District		
	C. E. Cawvey	James B. Stotlar
Piatt County—7th District		
	Joseph F. Allman	George G. Green
Pike-Calhoun County—6th District		
	Meyer Shulman	James E. Goodman
Pulaski County—10th District		
	A. L. Robinson	J. Conger
Randolph County—10th District		
	Orlan W. Pflasterer	Willard W. Fullerton
Richland County—8th District		
	William A. Moore	John P. Doenges
Rock Island County—4th District		
	Theodore Grevas	Raymond Dasso
	Joseph Gustafson	Harry Kutsunis
St. Clair County—10th District		
	Vivien P. Siegel	Harold McCann
	William H. Walton	Lloyd Walk
Saline-Pope-Hardin County—9th District		
	Neill A. Thompson	Douglas A. Lehman
Sangamon County—5th District		
	Preston V. Dilts	Floyd S. Barringer
	Chauncey Maher	Ross Schlich
	A. R. Eveloff	Richard F. Herndon
Schuyler County—4th District		
	Henry C. Zingher	Rosemary Utter
Shelby County—7th District		
	H. H. Pettry	Duncan Biddlecombe
Stephenson County—1st District		
	Thos. A. Haymond	H. R. Osheroff
Tazewell County—5th District		
	Robert L. Tucker	Joseph Aronoff
Union County—10th District		
	William H. Whiting	
Vermilion County—8th District		
	G. L. Seitzinger	Edwin G. Andracki
Wabash County—9th District		
	R. A. Richey	Donald R. Risley
Warren County—4th District		
	Richard Icenogle	Kenneth Ambrose
Washington County—10th District		
	Jerry Beguelin	William P. Lesko
Wayne County—9th District		
	Charles J. Jannings	Edward S. Talaga
White County—9th District		
	John A. Stricklin	Julius G. Harrell
Whiteside County—2nd District		
	C. J. Mueller	Isaac Vandermyde
Will-Grundy County—11th District		
	Robert J. Becker	Barry S. Seng
	Lloyd W. Jessen	Geo. H. Woodruff
Williamson County—9th District		
	Herbert V. Fine	
Winnebago County—1st District		
	Paul A. VanPernis	L. P. Johnson
	Harold E. Zenisek	E. T. Leonard, Jr.
	F. A. Munsey	Harry E. LaPlante
Woodford County—2nd District		
	J. W. Riley	

AGENDA FOR THE 1966 MEETING OF THE HOUSE OF DELEGATES

First Session: Sunday Afternoon
May 15, 1966
3:00 p.m.

1. Call to order by the Speaker of the House —Edward W. Cannady
2. Invocation
3. Roll call
 Report of the Committee on Credentials
4. Report of the Committee on Rules and Order of Business
5. Approval of the minutes of the May, 1965 meeting of the House of Delegates
6. Remarks of the Speaker of the House: Edward W. Cannady
7. Memorial Service for members of the Illinois State Medical Society who have passed away since May, 1965: Jacob E. Reisch, *Secretary*

8. Introduction of representatives of the Student American Medical Association chapters:
 Chicago Medical School
 Northwestern University Medical School
 Stritch School of Medicine—Loyola
 University of Chicago School of Medicine
 University of Illinois College of Medicine
9. Remarks — President, Illinois Chapter, Medical Assistants Association: Miss Sue Karels
10. Introduction of representatives of other state medical societies, past presidents and honored guests: Burtis E. Montgomery, *President*
11. Presentation of AMA-ERF checks to representatives of the five medical schools in Illinois: Carl E. Clark, *Chairman*, Finance Committee of the Board of Trustees; acceptance by Richard Young, Dean, Northwestern University Medical School
12. President's Address: Burtis E. Montgomery, Harrisburg
13. Special report to the House of Delegates: Mrs. John W. Koenig, *President*, Woman's Auxiliary
14. Special report of the Executive Administrator: Robert L. Richards
15. Report of Opinion Research Survey: Robert Best, Opinion Research Corp.
16. Announcement of reference committees for the 1966 House of Delegates: Edward W. Cannady, *Speaker*
17. Introduction of supplementary reports, including Chairman of The Board of Trustees and Chairman of Finance Committee:
 Referral to correct reference committee
 Edward W. Cannady, *Speaker*
18. Unfinished business
19. New business
 A. Introduction of resolutions
 Referral to correct reference committee
 Edward W. Cannady, *Speaker*
 B. Other new business
20. Recess.

Second Session: Tuesday Afternoon
May 17, 1966
2:00 p.m.

1. Call to order by the Speaker of the House —Edward W. Cannady
2. Roll call
 Report of the Committee on Credentials
3. Report of the Committee on Rules and Order of Business
4. Selection of the meeting place for 1969 annual convention
5. Reports of reference committees:
 A. Amendments to Constitution and Bylaws
 B. Reference Committee on Administration A. Administrative Reports
 C. Reference Committee on Administration B. Reports of Officers
 D. Reference Committee on Economics and Insurance
 E. Reference Committee on Legislation and Public Affairs
 F. Reference Committee on Public Relations
 G. Reference Committee on Publications and Scientific Services
 H. Reference Committee on Miscellaneous Business
6. Unfinished business
7. New business
 A. Communications
 B. Election of Emeritus Members
 C. Election of Retired Members
 D. Other new business
8. Recess

Third Session: Wednesday Afternoon
May 18, 1966
2:00 p.m.

1. Presentation of the CAMP LECTURE
 Introduction by Burtis E. Montgomery, *President*
2. Call to order by the Speaker of the House of Delegates: Edward W. Cannady
3. Induction of the president elect, Caesar Portes of Chicago, into the office of president of the Illinois State Medical Society by the retiring president, Burtis E. Montgomery, Harrisburg. Presentation of President's Certificate to Dr. Montgomery by Jacob E. Reisch, *Secretary*
4. Roll call
 Report of the Committee on Credentials
5. Report of the Committee on Rules and Order of Business
6. Announcement of awards to Scientific Exhibitors: Coye C. Mason, *Director and Chairman*, Committee on Scientific Exhibits
7. Election of Officers
 President Elect
 First Vice President
 Second Vice President
 Secretary-Treasurer
 Speaker of the House of Delegates
 Vice Speaker of the House of Delegates
8. Election of Trustees

Trustee District	Term expires:
Third	Philip Thomsen
	J. Ernest Breed
Sixth	Newton DuPuy
Ninth	Charles K. Wells
Tenth	Willard C. Scrivner

9. Election of delegates to the American Medical Association

(To take office January 1, 1967 and serve for a term of two years)
Terms expiring: Maurice M. Hoeltgen
Leo P. A. Sweeney
H. Close Hesseltine
William K. Ford
Burtis E. Montgomery

10. Election of alternate delegates to the American Medical Association
(To take office January 1, 1967 and serve for a term of two years)
Terms expiring: Theodore R. Van Dellen
Allison L. Burdick
Arkell M. Vaughn
Paul A. Dailey
Fred C. Endres
11. Election of Members of Standing Committees as provided in the Bylaws

COMMITTEES ELECTED BY THE HOUSE OF DELEGATES

A. Disaster Medical Care—Two members elected for a three-year term
Terms expiring:
Richard V. Lee, Carbondale
Carl F. Steinhoff, Chicago
B. Grievance Committee—Two elected for a three-year term
Terms expiring:
Frank H. Fowler, Chicago
Victor V. Rockey, Freeport
C. Laboratory Evaluation — Two Elected for a three-year term
Terms expiring:
John Maloney, Normal
Jack Williams, Chicago
D. Committee on Medical Education—Two elected for a three-year term
Terms expiring:
Daniel Ruge, Chicago
Mather Pfeiffenberger, Alton
E. Committee on Occupational Health—Two elected for a three-year term
Terms expiring:
Charles Asbury, Peoria
Arthur S. J. Petersen, Chicago
F. Prepayment Plans and Organizations —Two elected for a three-year term
Terms expiring:
Philip C. Lynch, Decatur
H. Kenneth Scatliff, Chicago
G. Committee on Public Safety — Two elected for a three-year term
Terms expiring:
Edwin A. Lee, Springfield
Clifford P. Sullivan, Chicago
One member for a one-year term in 1966
Term expiring:
Norman J. Rose, Springfield

12. Fixing per capita assessment for 1967
13. Any additional reference committee reports not presented at the second session of the House held on Tuesday, May 17, 1966
14. Unfinished business
15. New business; IMPAC Report — Philip Thomsen; Future Legislative Activities—V. P. Siegel
16. Adjournment, sine die.

COMMITTEES FOR 1966 HOUSE OF DELEGATES

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof. The committee shall pass out and receive the attendance slips and perform such other duties as may be assigned by the speaker.

The committee shall meet at least one hour prior to the time scheduled for the opening of the House of Delegates. The present schedule is:

Sunday, May 15	2:00 p.m.
French Room 107	
Tuesday, May 17	1:30 p.m.
Foyer of the Louis XVI Room	
Wednesday, May 18	1:30 p.m.
Foyer of the Louis XVI Room	

F. W. Young, *Chairman*
Wayne Leimbach, *Vice Chairman*
R. V. Kochanski — L. T. Fruin
Robert R. Mustell — J. J. Grandone

COMMITTEE ON RULES AND ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods of procedure, and the order of business (agenda) for the sessions of the House of Delegates. It shall work in close co-operation with the Speaker and Vice Speaker of the House of Delegates.

The committee shall contact the speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

Charles P. McCartney, *Chairman*
Burton Soboroff — Boyd E. McCracken
Anna Marcus — J. M. Ingalls

The first meeting of the committee should be scheduled on Sunday morning, May 15, in order to have a report ready to present as the first report scheduled at the opening session of the House on Sunday afternoon.

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the speaker of the House of Delegates whenever a vote count is called for, whenever a ballot vote is scheduled, or the House goes into executive session.

William H. Walton, *Chairman*

C. J. Mueller — Glenn A. Burckart
M. J. McAndrew — C. A. Norberg

REFERENCE COMMITTEE ON ADMINISTRATION "A" (Finance)

Meeting: 7:30 p.m.
Sunday, May 15 — Old Chicago Room 101

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Treasurer of ISMS (AF-1) (including the audit for 1965 and the proposed budgets for 1966 and 1967)
- Executive Administrator (AF-2)
- Committees on:
 - Archives (AF-3)
 - Benevolence (AF-5)
 - Student Loan Fund (AF-4)
- Delegates to the AMA (AF-6)
- Educational and Scientific Foundation (AF-7)

Noel G. Shaw, *Chairman*

Stanley E. Ruzich — Grover L. Sietzinger
A. A. Zanette — T. P. de Graffenried

REFERENCE COMMITTEE ON ADMINISTRATION "B" (Reports of Officers)

Meeting: 7:30 p.m.
Sunday, May 15 — Jade Room 103

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- The President (AO-1)
- The President Elect (AO-2)
- The 1st Vice President (AO-3)
- The 2nd Vice President (AO-4)
- The Secretary (AF-1)
 (Leadership Conference, State Fair, etc.)
- The Trustees of the 11 Trustee Districts
- The Speaker and Vice Speaker of ISMS House (AO-T1 through AO-T11)
- The Chairman of the Board of Trustees (AO-8)
- The Policy Committee (AO-9)
- The Committee to Study Committees (AO-10)
- The Ethical Relations Committee (AO-11)
- The Membership Committee (AO-12)
- The President of the Woman's Auxiliary (AO-6)
- The Advisory Committee to the Woman's Auxiliary (AO-7)

Paul W. Sunderland, *Chairman*

Maurice D. Murfin — Joseph F. O'Malley
W. D. McQuiston — George H. Irwin

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

Meeting: 7:30 p.m.
Sunday, May 15 — Holiday Room 105

This committee shall consider and report to the House of Delegates, its recommendations on all proposed amendments to the Constitution and Bylaws.

Keith H. Frankhauser, *Chairman*

John P. Pope — Allison L. Burdick, Sr.
A. R. Eveloff — Clifton L. Reeder

REFERENCE COMMITTEE ON ECONOMICS & INSURANCE

Meeting: 7:30 p.m.
Sunday, May 15 — Gold Room 114

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Committee on Aging (EI-1)
- Advisory Committee—Illinois Department of Public Aid (EI-2)
 Also Mr. Harold Swank's report as Director, State Department of Public Aid—to be found as a part of the report of the Chairman of the Board of Trustees (AO-8)
- Drug Manual Committee (EI-3)
- Fee Schedules (EI-10)
- Committee on Hospital Relations (EI-9)
- Liaison to Blue Cross-Blue Shield (EI-6)
- Medical Economics (EI-8)
- Rehabilitation Service (EI-4)
 Also Mr. Slicer's report as Director, Division of Vocational Rehabilitation—to be found as a part of the report of the Chairman of the Board of Trustees (AO-8)
- Prepayment Plans and Organizations (EI-7)
- Relative Value Committee (EI-5)
- Committee on Usual and Customary Fees (EI-11)

Paul A. Van Pernis, *Chairman*

Joseph A. Werth — Clair M. Carey
J. P. Schweitzer — George C. Turner

REFERENCE COMMITTEE ON LEGISLATION & PUBLIC AFFAIRS

Meeting: 7:30 p.m.

Sunday, May 15 **Ruby Room 113**

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Committee on Impartial Medical Testimony (LP-3)
- Laboratory Evaluation (LP-8)
- Legislation (LP-1)
- Liaison—Illinois Department of Registration & Education (LP-5)
- Medical Legal Committee (LP-4)
- Narcotics and Other Hazardous Substances (LP-9)
- Occupational Health (LP-7)
- Quackery (LP-6)
- Public Affairs (LP-2)

C. J. Jannings, III, *Chairman*

Joseph R. Mallory — Harold A. Sofield
Albert F. Fricke — H. W. Schneider

REFERENCE COMMITTEE ON PUBLICATIONS & SCIENTIFIC SERVICES

Meeting: 7:30 p.m.

Sunday, May 15 **Time Room 110**

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Illinois Medical Journal
 - The Editor (PS-3)
 - The Editorial Board (PS-1)
 - The Journal Committee (PS-2)
- The Annual Convention
 - The Committee to Study the Annual Convention (PS-5)
 - The Committee on Scientific Assembly (PS-4)
 - The Committee on Scientific Exhibits (PS-6)
- Cancer (PS-7)
- Cardiovascular Disease (PS-8)
- Child Health (PS-9)
- Continuing Education (PS-10)
- Environmental Health (PS-11)
- Eye Health (PS-12)
- Maternal Welfare (PS-13)
- Medical Education (PS-14)
- Mental Health (PS-16)
 - Report of Dr. Visotsky as Director, Illinois Department of Mental Health to be found as a part of the report of the Chairman of the Board of Trustees (AO-8)
- Nursing (PS-17)
- Nutrition (PS-18)
- Perinatal Mortality (PS-19)
- Public Health
 - Report of Dr. Yoder as Director, Illinois Department of Public Health to be found as a part of the report of the Chairman of the Board of Trustees (AO-8)
- Radiation (PS-20)
- Tuberculosis (PS-21)
- Standard Vital Certificates (PS-22)

Charles J. Weigel, *Chairman*

C. Malcolm Rice, Jr. — James P. Campbell
Edward J. Krol — Peter C. Rumore

REFERENCE COMMITTEE ON PUBLIC RELATIONS

Meeting: 7:30 p.m.

Sunday, May 15 **French Room 107**

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Advisory Committee to the Medical Assistants Association (PR-3)
- Advisory Committee to the Health Careers Council (PR-4)
- Advisory Committee to Student American Medical Association (PR-8)
- Disaster Medical Care Committee (PR-7)
- Fifty Year Club Committee (PR-5)
- Grievance Committee (PR-6)
- Public Safety Committee (PR-2)
- Committee on Religion and Medicine (PR-9)

George W. Holmes, *Chairman*

E. J. Lukaszewski — A. L. Robinson
John D. McCarthy — Mather Pfeiffenberger

REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Meeting: 7:30 p.m.

Sunday, May 15 **Orchid Room 106**

This committee shall consider and submit its recommendations to the House of Delegates upon all matters referred by the speaker, and also upon the reports of:

- Advisory Committee to Selective Service (MB-3)
- Liaison Committee to Illinois Osteopathic Association (MB-2)
- Liaison Committee to Illinois Pharmaceutical Association (MB-1)
- Committee on Illinois Association of the Professions (MB-4)
 - Interprofessional Council Sub Committee

Vincent Freda, *Chairman*

John M. Coleman — Chauncey C. Maher
Eugene M. Narsete — Richard Icenogle

ANNUAL REPORTS



OFFICERS AND TRUSTEES

PRESIDENT
AO-1

During my year as president many changes have been indicated in the future because of the passage of federal legislation which makes it possible for government to control a much greater portion of medical care of those over age 65 and those who are below the age of 21. In my travels and presentations to county medical societies, I am convinced that many of our members do not read the information which they receive from the State Medical Society and the AMA.

Membership appears to be critical of the organization which for almost 20 years withstood the schemes of medical planners to reorganize the services provided to our patients through a government medical care program. Unfortunately, our membership does not recognize the wide ramifications of those things that have been done by the AMA and the State Medical Society for the protection of the private practice of medicine. I attribute this primarily to lack of interest and busy schedules which do not allow for time to investigate and study what is happening. I have so indicated this conclusion in articles which I have prepared for publication in the I.M.J., and in my presentations to county medical societies.

As you all know, I would do anything in the world to have the membership understand and cooperate insofar as the activities of their state and national medical societies are concerned. I ask that in the future, county societies provide in their programs for a meeting with their trustee and the officers and staff of the State Medical Society, as well as delegates to the AMA. Our officers and staff stand ready and willing to provide this type of service to you and your counties.

In recent months the Finance Committee of the state medical society has been presenting to the county societies a discussion on the services and finances of the state medical society. In each case, as far as I know, the counties have been well satisfied after the presentation was completed. Many of us in

the medical profession have been shortsighted because we have complained about dues. The only time we seem to create an interest from our members is when we touch their pocketbooks. I suggest that if there should be any question about the budget for the year 1966 and 1967 which will be presented to the House of Delegates, that you and your society invite the Chairman of the Finance Committee to discuss this most interesting topic with you at an early meeting of your county society.

Your president also serves as a delegate to the AMA. It was my privilege to serve as Chairman of the Reference Committee at the Special Session of the AMA House of Delegates on October 2-3, 1965. It was at this meeting that the AMA's present position with respect to the implementation of Medicare was determined. The report of the ISMS delegation to the AMA will provide the details. However, at the time of the meeting there was great concern regarding the question of participation vs. non-participation. There was also a question raised regarding the formation of a guild of physicians, which would be the equivalent to a union. It was my personal privilege to read the legal opinion of the AMA regarding the subject of participation. The General Legal Counsel of the State Medical Society has since concurred in that opinion. The law provides that a physician may choose himself whether or not he wishes to participate. Let me assure you that insofar as I am able to predict, there will be no compulsory participation, and a physician is at liberty to use his own personal judgment in this matter.

Physicians' Guild

With respect to a guild of physicians, it was also my personal privilege to investigate the legal ramifications of this proposal. After consultation with the Law Department of the AMA, and the General Legal Counsel of ISMS, it is my understanding that a guild which might operate in the form of a union is not possible under the present laws of our nation, and would definitely be against the Sherman Anti-trust Act.

In respect to these legal opinions it is my feeling that more today than at any time in the past it will be necessary for our presently constituted organization to develop increased leadership at all levels. I recommend that county medical societies consider seriously their role in providing medical statesmen and leadership to the State Medical Society, and thus to the AMA.

With respect to leadership I cannot help but compliment our Secretary-Treasurer in his planning for a Leadership Conference to be held in Springfield just prior to our Annual Meeting. The Leadership Conference has been approved by our Board of Trustees to bring to the attention of all officers of county societies the mechanisms which might be employed to develop medical statesmanship, as well as programs which will enhance the personal stature of the physician and his organized societies.

Opinion Research Study

To be presented to the House of Delegates will be the results of an Opinion Research Study approved by the Board of Trustees and implemented since January 15, 1966. It was my privilege and pleasure to endorse this survey so that we might determine in the face of what appeared to be criticism of the Society, exactly what the general membership would have us do in future years. I have no idea what the results of that study will be at the time of the preparation of this report. But I am reasonably convinced that our membership will generally support the present activities of the State Medical Society, and ask for more service rather than less.

Having served on the Board of Trustees since 1951, I had the opportunity to participate in the growth and development of our present program, as well as the employment and supervision of the present Executive Administrator and staff. Those of us who have been close to this development recognize the many man-hours of time, and the fine contributions which have been made by our committees and staff to the Society. I would like to state here and now that our present staff under the most able leadership of Bob Richards, is second to none in this country. I know it is impossible for those in the House of Delegates to understand the deep sense of gratification which I have to those who have served with me in the past, and the anticipation I continue to have for working with the officers of ISMS.

Although I am completing my fifteenth year of service on the Board of Trustees as an officer, and will from henceforth devote a considerable portion of my time to the AMA, if elected as a trustee in June of 1966, it will be my pleasure to assist those who succeed me at any time they may request my personal time or services.

I conclude my year as president with deep appreciation to those who have served with me, especially the Chairman of the Board of Trustees, Doctor Adams; the President-Elect, Doctor Portes; Mr. Richards, and the Staff. It has been a distinct privilege and pleasure to work with them during this year.

B. E. Montgomery, *President*

PRESIDENT-ELECT
AO-2

The length of my report in no way reflects the amount of time devoted to various activi-

ties connected not only with the office to which I have been elected, but also to the Illinois State Medical Society and its many programs and assignments.

I have made many talks before various groups, on radio and television, to represent the Society. Some of these presentations came to me as President-Elect, and others were referred to me by the President when he was unable to fill certain engagements due to a conflict in dates or an inability to attend because of the distance involved.

The responsibilities assigned to your President are increasing, and the importance of the year as President-Elect is more and more obvious. This would be especially true if the physician selected were without experience as a member of the Board of Trustees. The year is none too long to absorb procedure and policy and become adjusted to speaking as the official representative of over 10,000 Illinois physicians.

I shall look forward to the coming year as President of this Society, and I take this opportunity to thank you again for the honor given to me.

Caesar Portes, *President-Elect*

FIRST VICE PRESIDENT
AO-3

In serving the ISMS as your first vice president, the records will show that I have been anything but inactive and confined to that chair of relaxation associated with impotence and sterile neutralism.

I have participated in the scheduled meetings of the Board of Trustees of the ISMS and each time planted a few more seeds of human liberty and freedom in the minds of those who would guide you in the establishment of policies and procedures that would promote political and medical freedoms, both of which are essential to quality and quantity of medical care.

I have spent many hours in detailed analysis of the problems that confront the ISMS. In addition, I have pointed out our objectives, our shortcomings as well as our beneficial aspects as a prelude to the development of a positive strategy. My observations and recommendations concerned themselves with ideas that would enhance the respect of men in medicine for their leadership and the respect of people for their doctors.

I attended many meetings on medical affairs, including two meetings of the AMA. I participated in the open hearings of these meetings and offered remarks that I felt would enhance the position of organized medicine.

In a three hour interview with Mr. O'Neil, a representative from Opinion Research, I made many recommendations which I felt would be helpful in giving the ISMS added strength.

In finalizing my year of assignment as first vice president of the ISMS, I would be derelict in my conscience if I did not propose a single, and in my mind most significant, resolution. I would propose that this House of Delegates adopt "The Free Society Philosophy" as a basis for ISMS policy and action, and that by definition and delineation it preserve and promote:

1. The concept of LIMITED GOVERNMENT
2. The rights of people to have the freedom to create and perform peacefully and without fraud or violence with their God-given talents and acquired knowledge
3. Free and open markets for all products and services, including the practice of medicine
4. Economic growth by the investment of private and not governmental funds.

In order to generate and organize sound ideas and communicate them effectively to our doctors and the public at large, I would ask for the appropriation of $2,500 to be allocated out of funds assigned to the public relations and public affairs committees. No increase in dues would be indicated.

These monies would be used to finance a short educational program to learn the art and science of communicating ideas effectively. A total of twelve select officers and staff would be exposed to proven methods of obtaining willing acceptance of ideas which would be useful in all ISMS activities.

Ineffective methods and poor results have many times been our reward only because methodology and direction of efforts have been inadequate.

I beg your vote to adopt the resolution of the "Free Society Philosophy," as defined and delineated. I would also ask your approval of the funds essential to get this program on the road.

Michael R. Saxton, *First Vice President*

SECOND VICE PRESIDENT
AO-4

Since this incumbent has taken office, many momentous things have happened in relation to the profession of medicine and the practice of medicine. Public Law 89-97 has been enacted into law and becomes effective July 1, 1966. This is the beginning of the socialization of medicine. Sad, but true.

The officers and delegates of the Illinois State Medical Society have been extremely active since the bill became law and have sought a more thorough understanding of what

is to be expected of the profession of medicine. They have been instrumental (in part) in making some changes in the interpretation and have reported such to the Board of Trustees. A great deal of clarification still needs to be made, but it is hoped that with the passage of time more light will be thrown on the subject for an intelligent compliance with the law.

There is no question but that we as physicians should make every attempt to adhere to the strictest letter of the law and make every effort through proper channels, to bring about such changes in the law that will be beneficial to the people, the country, and profession of medicine. It is hoped that more physicians will become active in helping to create a more favorable atmosphere in the legislative halls of Congress in order to make such changes possible. The officers, members of the Board of Trustees and all the various committees have spent a great deal of time and effort to bring to the membership at large what information they have been able to gather.

It is also suggested that both Vice Presidents of this Society shall be given a vote at the meetings of the Board of Trustees. They are invited to attend Board meetings and may discuss questions which arise, but they are not permitted to make motions nor to cast a vote. This is not in keeping with the dignity of the offices and should be changed by recommendation of the Constitution and Bylaws Committee.

The past year has been a most gratifying and enlightening one.

Casper M. Epsteen, *Second Vice President*

SECRETARY
AO-4

Report of the Secretary-Treasurer (AF-1) will be found under Administrative Reports.

FIRST DISTRICT
AO-T1

The county medical societies of the First District, both large and small, have maintained a stable number of members during this year. This is of interest in that an expanding but shifting population has produced no change in physician numbers.

These societies have been individually active in many ways. A successful health fair reached many people in the Rockford area, both in Winnebago and surrounding counties. A public affairs meeting at Kane County, in cooperation with its neighbor, DuPage, was attended by over 300 physicians and their wives. McHenry and Lake Counties were invited to participate. Lake County preceded this meeting with one of its own. The district committee on aging, acting as a pilot study for the Illinois State Society Committee on Aging, is diligently proceeding with its planning program, and survey of aging needs. Several counties have asked and received help in presenting information programs in which the trustee and staff members of the state society office have brought to the membership facts about services available to members. The trustee has assisted with this program in other counties outside of the district. Many counties, especially Lake County, have entered into joint meetings with the interprofessional organization. Nearly all provide meetings between the bar association, and several counties have conducted informational meetings with the ministerial associations to further the AMA's program of Medicine and Religion.

The auxiliaries of those counties which support such associations have continued to be active in promoting medicine's cause. Those societies which do not have auxiliaries are encouraged to do so. I feel sure that some problems in the public relations area suffered in some counties could be decreased, or even avoided, had there been an active auxiliary to carry their cause to the public. Kane, DeKalb, Winnebago and McHenry counties sponsor medical assistants groups and other counties would gain markedly by underwriting this group of energetic friends of medicine, both by providing themselves with better qualified assistants as well as adding numbers to a public relations program.

An assembly of district delegates will be attempted before the annual meeting. This meeting is useful to further learn of local problems and to maintain closer relations with and provide information for the delegates and to increase their efficiency in providing the local society with progress and functions of the state society.

The problems of Medicare distress many and Monday morning quarterbacking has become prevalent in some county medical societies with some members feeling that the state and national associations could have done better, in prevention of socialization's onslaught. Most members feel however that such an attitude is shortsighted. Those who criticize the long-continued efforts of yesterday forget that the cause was lost to overwhelming political pressure. Those who criticize political action can hardly justify this feeling in the face of modern political conduct. The average member knows this, and regrets the assumption of the less informed and perhaps more vocal members.

Scientific programs, many provided by the postgraduate educational services of the state society are usual in all societies at regular meetings. All but a very few societies meet

monthly. At many of these meetings, awards have been presented to the individuals. This includes 50-year awards and awards to communication media representatives, to name only a few.

Your trustee appreciates the cooperation of members and officers of all the societies. Those executive secretaries, as well as the over burdened physician secretary have responded to all requests for help and information. Your confidence is a great help to representing you. I feel honored because of it.

Carl E. Clark, *Trustee*

SECOND DISTRICT
AO-T2

The county medical societies of the Second District have been active through the past year under the able administration of their officers and committees. At the time of this report there are no resolutions from the county societies for presentation to the House of Delegates at the annual meeting in May, 1966.

The professional membership of the district has remained practically the same as that of the preceding year.

The county societies have held periodic scientific meetings—availing themselves of speakers from the Scientific Speakers Bureau or from the Foundation programs.

During the past year it has not been necessary to convene the Ethical Relations Committee, the Grievance Committee, or the Prepayment Plans Committee.

LaSalle County made use of a headquarters office service by hearing a presentation of the dues and finance structure of the state society correlated with the many activities of the state society. This was a very informative program and I would recommend that other county societies avail themselves of the presentation which was ably discussed by Dr. Jacob Reisch, Secretary-Treasurer, and Mr. Robert Richards, Executive Administrator of the state society.

Whiteside County has appointed a committee from its own membership to keep it updated on the rules and regulations regarding the implementation of Medicare. The society has also endorsed a measles immunization program which included the immunization of the medically indigent free of charge in the doctor's office with the amount of vaccine available from the state department of health. This was a good example of community professional public service.

In January a district meeting was held in LaSalle. The program consisted of a panel presentation concerning Medicare and other amendments to the Social Security Act. Participating on the panel were H. Close Hesseltine, M.D.; Maurice M. Hoeltgen, M.D.; Roger Sondag, M.D., and Robert Richards, Roger White, and Walter Livingston of the headquarters staff, and your trustee. The meeting was well attended and stimulated much profitable discussion. A similar meeting for review of Medicare after it has been in effect has been planned for the fall of 1966.

Your trustee presented a fifty-year-in-practice certificate to Dr. Ernest G. Beatty of Pontiac. Your trustee also presented Public Service Awards to Mr. Richard Turnroth, of Sterling, and Mr. V. H. Eggers, of Princeton, for their participation in the outdoor advertising professional public service of the Illinois State Medical Society. LaSalle County Society presented a similar award to Mr. Russell Woodrich. The county societies of Lee and Woodford are to be congratulated on 100% payment of voluntary dues for 1965.

Your trustee presented to the Livingston County Medical Society a program on the implementation of Medicare and the policies of the Illinois State Medical Society in reference to Medicare.

Your trustee is a member of the Finance Committee and an ex-officio member of the Legislative Committee.

I wish to express my gratitude to the officers and members of the county societies for the cooperation and the courtesies extended to me. It has been a privilege to work with the officers and trustees, and committee members of the Illinois State Medical Society. I wish to thank the headquarters staff in both the Chicago and Springfield offices for the help and cooperation given to me.

Ralph N. Redmond, *Trustee*

THIRD DISTRICT
AO-T3

No report available.

FOURTH DISTRICT
AO-T4

This has been a busy year during which I have been pleased to meet a great number of Fourth District physicians, either at their county society meetings or at district events.

Warren County Medical Society proved a most gracious host at the fall Fourth District scientific meeting. Galesburg was the site of a recent session concerning the financing of our society activities.

In January, the 19th Congressional District Physicians' Committee held a legislative session in Moline; in February a similar event was held in Jacksonville to include the 20th Congressional District.

Several dinner meetings in the trustee district were scheduled as award events to present plaques to outdoor advertising firms for their cooperation with the Illinois State Medical Society in its public relations campaigns.

A lively interest in legislative affairs, public relations programs and scientific meetings continues into this new year. Area meetings to discuss the new UAW out-patient mental health benefits, which go into effect next September, are currently being arranged by the Zone Director of the Illinois State Department of Mental Health.

Several counties are active in Project Headstart; many are cooperating with schools in Health Careers and Science Fair exhibits. Peoria County, in addition, reports holding meetings with local industry on the subject of health insurance; the planning of a medical tour to Europe in the fall of 1966; and continued effort to bring a medical school into that area.

Each county has submitted reports to your trustee showing activities, officers elected and membership totals. It appears that there are now 574 members in the Fourth District—a gain of 18 over last year.

I would advise that future educational meetings be held in some of the smaller counties, not only for the increased fellowship which they would provide, but also because of the excellent cooperation and sincere interest shown by several of these societies during the past year.

I am most grateful for this spirit and I hope to see it grow.

Paul P. Youngberg, *Trustee*

FIFTH DISTRICT
AO-T5

During this past year, the eight component societies of the Fifth District continued to be active and cooperate in state society projects. The larger county societies hold monthly meetings with good scientific programs. The smaller county societies hold meetings every two months, or by their own definition, "sporadically." Attendance, however, except at meetings involving changes in local dues, continues to be poor and forever plagues the program chairman and the officers.

The Sangamon County Society is now studying the possibility of three or four instead of 10 meetings a year. This development may bear watching and be the answer for better attendance.

The larger county societies continue to practice better public relations by joint dinners and dinner-dances with other professional groups such as the Bar Association, Pharmaceutical Association, ministerial groups, etc. Needless to say, the wives in the auxiliary made these events most successful.

The Illinois State Medical Society had another outstanding exhibit at the Illinois State Fair for the fifteenth consecutive year. Dr. SIMS, assisted by the ladies of the Sangamon County Medical Auxiliary, made a great hit with the fair goers. I would urge that we continue to give this project high priority and support.

At the time of this writing, the Fifth District has been involved with three public affairs meetings; two in the 20th Congressional District were held in Jacksonville on November 3 and February 13. Congressman Paul Findley was able to attend the February 13 meeting and this trustee was privileged to serve as chairman. Congressman Findley has continued to grow in stature in Washington and has continued to be a friend of medicine.

The McLean County Medical Society and Auxiliary had a public affairs meeting on January 11. This was well attended and a lively discussion ensued.

A number of the component societies have been visited and I hope to be able to visit the rest by the time of the Annual Meeting.

As your trustee, I have attended all of the meetings of the Board of Trustees to date.

May I extend my thanks to the officers and members of the county medical societies for the many courtesies and hospitality shown me. I am deeply appreciative of the cooperation and kind consideration shown me by the delegates of the component societies, my fellow trustees, the state society officers and last, but not least, the state society staff.

Darrell H. Trumpe, *Trustee*

SIXTH DISTRICT
AO-T6

The constituent medical societies of the Sixth District efficiently conduct scientific and business programs with loyal and intelligent leadership. The Illinois State Medical Society honored this district for achieving the highest membership participation in public affairs. Recognition awards were presented to the various societies. The physicians of this district continue to interest themselves in state and national affairs. The Ethical Relations, Prepayment Plans, and Grievance committees are organized. It is fortunate that the Grievance Committee has had no occasion to meet. At the request of the Medical Advisory Committee to the Illinois Public Aid Commission, a committee was named for the purpose of investigating public aid medical service. Members of the committee are Dr. Richard Cooper, of Quincy, and Dr. Willis W. Bowers, of Granite City, with Dr. Paul Dailey, of Carrollton, as

chairman. Morgan County Medical Society was host to the annual public affairs meeting and the Madison County Medical Society will be host for the annual delegates' meeting.

The medical auxiliaries continue to be active; one of their charming members is President-Elect of the Woman's Auxiliary to the Illinois State Medical Society.

The Hon. Paul Findley's stature in Congress was definitely established when he was selected in the top 10. In our book he is number one. His "Committee of Physicians" has attracted national attention.

Your trustee has been present at each meeting of the board and serves on several committees within the board. For the many courtesies and for the warm hospitality from the physicians of this district, I am most grateful. I also wish to express my thanks to the Executive Administrator and his staff for their considerable help and cooperation.

Newton DuPuy, *Trustee*

SEVENTH DISTRICT
AO-T7

Membership throughout the Seventh District continues practically unchanged. The losses by death and replacement by new members have been nearly equalized.

There has been no call from any of the three District Committees since the 1965 report.

Medicare has presented major problems from the utilization committees' standpoint. All hospitals in the area and their staffs are working on programs of utilization review. These are very complex and will take considerable time to work them out.

The new health legislation, as it was projected, took considerable of your trustee's time. He was one of those called to the orientation meeting in Washington, D.C., in July of 1965 on the Heart disease—Cancer—Stroke bill, being one of two from the 22nd Congressional District to meet with his congressman, who was a member of the committee having hearings upon the projected act. He also attended as a delegate to the American Medical Association from Illinois, the special session of the AMA House of Delegates in Chicago in October of 1965, and then to the interim session of the American Medical Association at Philadelphia November 30 through December 2, 1965.

The Seventh District contributed three new members to the Fifty-Year Club. Dr. William L. Hall was awarded his Fifty-Year certificate and pin on September 16, 1965, at the Greenville Country Club. Dr. Opal H. Lowder, of Stonington, was presented his Fifty-Year certificate and pin on November 9, 1965 at the Pana Country Club, and on December 15 at Breeze, Dr. Ernest C. Asbury, of New Baden, was awarded his Fifty-Year certificate and pin.

Your trustee has not had an occasion to meet with the Woman's Auxiliary this year, but has been kept informed as to their many activities.

To summarize, the 11 societies of the Seventh District had a normally active year. The many problems that have arisen due to the medical legislation during 1965 are being worked upon diligently.

Your trustee again extends his appreciation for the continued cooperation of the constituent medical societies and auxiliaries during this past year.

Arthur F. Goodyear, *Trustee*

EIGHTH DISTRICT
AO-T8

The activities of the trustee from the Eighth District have been diversified since the last report.

In July, 1965, at the request of the AMA and the ISMS, a trip was made to Washington, D.C., to confer with Representative William L. Springer, representing the 22nd District and with Representative Leslie Arends, House Minority Whip, regarding the impending legislation of the Heart—Cancer—Stroke bill. As a result of this visit, the bill was considerably amended and improved, although it was impossible to impede its passage.

While on vacation in September, I was contacted by the AMA and requested to discuss the legislation mentioned above once again with Congressman Springer. This I accomplished by telephone.

In October a postgraduate conference was held in Champaign covering such subjects as "The Management of Acute Burns," "Resuscitation of Multiple Injuries," and "The Management of Abdominal-thoracic Injuries." In the evening Dr. Burtis Montgomery addressed the group on the subject of Medicare. Seventy physicians from Champaign-Urbana and surrounding areas were in attendance. In October, also, a district meeting of the Woman's Auxiliary of the ISMS was held in Danville. The trustee attended and addressed the ladies briefly on the subject of Medicare. During this month I aided a citizen's committee from Mahomet, with the help of the Placement Bureau of the ISMS in its effort to procure a physician for the community after a vacancy was caused by the untimely death of the local doctor.

In November, at the request of the chairman of the Advisory Committee to the Selective Service Act of the ISMS, Dr. Carl Steinhoff, I

spent the day in Robinson interviewing doctors, the hospital administrator and the immediate past president of the county medical society in an effort to assist in reaching a decision as to the number of doctors who could be expended without altering the medical care of the citizens of that community and its service area. Also, during the month a plaque was presented to the president of a local outdoor advertising firm for his cooperation in placing posters relating to prevention of disease through immunization.

In December, a copy of the Medicare law and a pamphlet on the Social Security Act relating to physicians was sent to the officers and delegates of each county medical society recommending to them that each hospital staff appoint a Utilization and Review Committee consisting of members of the medical staff.

In January, the meeting of the Coles-Cumberland Medical Society was attended. A plaque was presented to the president of the Outdoor Advertising Company of that area for his cooperation as previously noted. The society was addressed on the subject of Medicare, pointing out the application thereof to the physicians and answering questions of the members on this and other subjects.

On February 19, a Public Affairs meeting was held in Champaign. The afternoon portion of the meeting was devoted to discussion of the bill pending in Congress regarding the use of animals in research. This meeting was attended by the deans of the medical schools of Northwestern University, University of Illinois and Chicago, and the deans of the veterinary schools. The evening meeting was attended by delegates from all of the county medical societies in Mr. Springer's congressional district. Representative Springer discussed the present, pending and future legislation relating to physicians. The Public Affairs section of the ISMS was represented by Mr. Roger White and the AMA representative in Washington, Mr. Foristal. Dr. Arthur Goodyear, trustee of the Seventh District, was also present.

It is contemplated to hold a district meeting previous to the annual meeting in Chicago to discuss reports of officers and committees as appearing in the delegate's handbook and any other business which may be presented.

I have also been present at all Board of Trustees meetings.

It has been both an interesting and productive year in which I have received a great deal of support from the membership of the county societies in my district. I also wish to extend my gratitude to the staff of the ISMS for their unfailing assistance to me in my duties as trustee.

W. H. Schowengerdt, *Trustee*

NINTH DISTRICT
AO-T9

Your trustee has attended meetings of most of the county medical societies in his district during the past year. Some of the county societies are composed of four to six members and seldom hold a meeting. One county has one active member at present, since the other two doctors in the county have retired.

Awards have been presented to the medical societies involved in recognition for participation in public affairs as well as the presentation of awards to two outdoor advertisers within the district.

The total membership in the Ninth District remains about the same—between 90 and 95 members. There appears little hope of much increase in membership because physicians appear not to be attracted to a rural practice. The largest town in the district is about 16,000. A new hospital opened in Harrisburg last year for the care of the mentally retarded. Staff physicians of this hospital should increase the membership of the Saline-Hardin-Pope County Medical Society by a few members.

The District Ethical Relations, Grievance and Prepayment Plans and Organizations Committees of the district had no problems before them the past year.

On November 4, 1965, a combined scientific meeting was held jointly between the Ninth and Tenth Districts in Belleville. This meeting had an attendance of about 150 doctors. Plans are now in progress for the combined meeting for 1966.

One county sponsored a cocktail party in conjunction with the Annual Chamber of Commerce Dinner. This particularly appeared to be a good public relations project. Representatives of the entire business community attended.

Scientific programs for the county medical societies are primarily obtained from Evansville or St. Louis. Probably it is felt that an attendance of 15 to 20 people in a single medical society meeting would be too small for a speaker to come from Chicago. Many physicians from the area attend the Academy of General Practice Postgraduate courses held in Centralia.

It is my impression that the elected officers of most of the medical societies carry out their duties adequately, but in small societies, their duties are minimal. Most doctors in the area are overburdened with patients and medical society functions are secondary.

On December 3, 1965, I attended a Legislation and Public Affairs program orientation course in Harrisburg which had representatives present from most of the counties in the 57th District. On December 15, 1965, I at-

tended a similar meeting in Farifield for the 55th District which also was well attended.

There are two schools of practical nursing in the Ninth District—one in Harrisburg and one in Mt. Vernon. Each graduates 18-22 graduates per year. Most of the graduates obtain jobs in local hospitals. A new school is being formed in Mt. Carmel.

All hospitals in the Ninth District are not accredited by the Joint Commission on Accreditation of Hospitals. Some hospitals have only three or four members on their active staff and with this number of physicians, it is almost impossible for them to qualify for accreditation.

A few new nursing homes are in operation in the district. I know one 100 bed nursing home has received its accreditation.

Your trustee met with his local County Board of Supervisors when the Home Health Care provision of PL 89-97 was discussed, and so far they have taken no action. I have talked with members of some other county societies who do not have a local health department and their Board of Supervisors so far has not acted on providing a County Board of Health.

It is my belief that if the larger county medical societies in my district would have combined meetings—two or three per year—good attendance could be obtained at scientific meetings.

I wish to thank the staff of Illinois State Medical Society for their help during the past year.

Charles K. Wells, *Trustee*

TENTH DISTRICT
AO-T10

Dates of visits and events

June 9, 1965: The St. Clair County Medical Society goes on record again as reaffirming its approval of the past policy of the East Side Health District in examining pre-school children and that any physical examination of school children performed by other physicians in St. Clair County be on his customary fee for service basis.

June 16, 1965: Visit to Perry County Medical Society, DuBois. Full membership and wives in attendance. Special feature, 50-year awards to Drs. Kelly and Culpepper.

June 25, 1965: St. Clair Medical Society luncheon at Holiday Inn, East St. Louis. Dr. Delyte Morris, president Southern Illinois University, principal speaker. Locating medical school in downstate Illinois main topic of discussion. Committee to be developed with Dr. Walton liaison. Meeting resulted in formation of citizens committee which presently is considering suitable candidates to be appointed to the higher education committee.

July 11, 1965: Briefing meeting with Dr. Wells, ninth district councilor; Dr. Mohlenbrock, secretary, Southern Illinois Medical Society; and others for programming forthcoming meeting in November—held at Tamaroa.

August 12, 1956: 8th annual medical auxiliary tea for Nurse Scholarship Association of St. Clair County was held in East St. Louis at which time 16 partial or complete scholarships were awarded. The county medical society representatives were among the 150 people in attendance from all interested groups.

September 6, 1965: This board had audience representation at the Labor Day program in Belleville, during which the senior senator from this state urged the people to grasp the hands of their doctors in thanks for the first constructive legislative contribution in proposing Eldercare; thereby enabling the planners to bring out a bill far more inclusive than they had ever hoped for. And, in warm terms equaling the sun's hot rays, he urged the workers to not only use one arm to gain advantages, but unlock the other to attain their needs through legislation to which they seem not to be strangers.

September 20, 1965: The Alexander County Medical Society, wives, and guests had a dinner and ceremony with press coverage in honor of Dr. J. K. Rosson, of Tamms, on the occasion of his 50-year award. One could not escape a deep sense of humility and admiration for this rugged, sole, 72-year-old medical shepherd in a village of 1,000 people.

October 14, 1965: Representatives of St. Clair County enjoyed the hospitality of adjoining Madison County Medical Society, Dr. DuPuy's district, and were privileged to hear Dr. Caesar Portes convincingly present a well documented resume on present significance and implementation of Medicare. His fundamental sincerity, lightened with anecdotes, clearly indicated accomplishment of his mission.

October 20, 1965: Some 50 citizens, representing the public group for medical education in southern Illinois, met in Belleville. The medical liaison member, Dr. Wm. Walton, is greatly impressed with the widespread interest and preliminary plans in the process of developing.

November 4, 1965: 91st meeting of Southern Illinois Medical Society. Joint meeting of 9th and 10th Districts at Belleville. Afternoon panel included officers' presentation of Public Law 89-97. Mr. Ross Randolph was

banquet speaker that evening. Fifty-one commercial exhibitors. Attendance of 123 physicians and wives.

November 23, 1965: Jackson County Medical Society at DeSoto. Presentation of public service award for mass media—to Mr. Fred Speers of Rodgers and Rodgers Advertising Company.

December 1, 1965: Washington County Medical Society meeting at Traveler's Cafe, Tamaroa. Awarding of voluntary contribution certificate by president, Dr. Fajans. Enjoyable discussion with doctors and wives on current problems.

December 4, 1965: St. Clair County Medical Society observing its 100th year anniversary, held annual dinner dance with presentation of plaques to 17 past presidents. Dr. Montgomery, state president, delivered main address. The medical society was awarded a plaque for their support of public affairs during 1965 —by trustee.

December 14, 1965: Special events orientation meeting for parts of Jackson and St. Clair Counties at Engel's Restaurant, Carbondale. Approximately 20 in attendance. Mr. Raber and Mr. Widmer spoke, with Dr. Malony as m.c., followed by inspiring remarks from Dr. Leo Brown. An AMA public affairs film was shown.

December 16, 1965: Monroe County Medical Society meeting at Bee Hive Restaurant, Waterloo. Distributed booklets on latest resume of Medicare which were furnished by state society. General discussion urging members toward activity in voluntary health organizations.

January 22, 1966: Attended Randolph County Medical Society with members and wives for dinner; presentation of current legislation, Medicare bill, nurse utilization, and home nursing implementation; solicitation of members for committee functions.

January 30 1966: Briefing meeting with Dr. Wells, 9th district councilor, for district meeting to be held November 3.

February 3, 1966: St. Clair County Medical Society meeting; presentation of public service award to Montgomery Advertising Company.

February 24, 1966: Annual banquet for student nurses sponsored by Nurse Scholarship Association of St. Clair County, St. Clair County Medical Society, and East St. Louis Chamber of Commerce.

Remarks

The shortage of general physicians and their unequal distribution throughout the district continues to be of primary concern to all interested parties.

It is my personal plea that each physician assume leadership role to strengthen the independent sector of our American society in an effort to contain ever increasing centralization of our government.

W. C. Scrivner, *Trustee*

ELEVENTH TRUSTEE
AO-T11

This being my freshman year as a trustee, I wish to proffer some comments upon my impression of the workings of the Board.

1) These men are truly dedicated to the cause of organized medicine.
2) They are extremely conscientious in their attempt to reflect the feelings of the majority of the members of the state society.
3) The volume of work and multitude of reports at quarterly meetings are almost overwhelming at times.
4) Decisions should be implemented by close adherence to the recommendations of committees, wherever they coincide with the policy of the ISMS.
5) There is still a 'dehiscence' between the Board of Trustees and the local county medical society. Perhaps more district meetings are indicated.
6) Due to much time with reports and correspondence, etc., the practice of medicine on an organized level is becoming more and more complex. It might be worthwhile having a member of the organizational staff of the ISMS assigned to each district to act as a coordinator for disseminating information and implementing actions taken by the House of Delegates as well as the Board of Trustees. This is especially true of county medical societies which are smaller and do not have paid administrators or secretaries.

Your trustee attended all the meetings of the Board during the past year, as well as having served on two committees of the Board, viz. the Committee to Study Committees, and the Ad Hoc Committee for Carriers for Part 'B' of Medicare.

It was my privilege and pleasure to meet with three of the county medical societies during the year at a county medical meeting. No formal attempt was made to discuss problems at these meetings. However, I trust some rapport has been established to keep these societies informed on Board activities.

Contact with the other societies in the Eleventh District has been maintained primarily via direct phoning and mailing. The members have been encouraged to contact the trustee regarding any local issues at any and all times.

Several special meetings have been conducted in this district during the past year, viz. P.R. meetings as well as a most informa-

tive combined meeting of Kane, Will-Grundy and DuPage County Medical Society doctors recently on the implementation of the Medicare act.

A study of the numerical number of members in the society reveals the following:

DuPage	—increase of 24
Ford	—decrease of 1
Iroquois	—increase of 1
Kendall	—decrease of 2
Will-Grundy	—decrease of 3
Kankakee	—increase of 6

The local societies were contacted regarding their internal activities for the year. Most have monthly meetings, Fall to Spring, all have P.R. activities. One county society reported a "medical careers night" being very well received, and that it considered the actions of the last House of Delegates in limiting such activity as being "shortsighted." This perhaps would bear investigation.

Joseph R. O'Donnell, *Trustee*

SPEAKER AND VICE-SPEAKER AO-5

The May, 1965, meeting of the House of Delegates was notable in many respects. Considerable time was spent by the delegates before the reference committees and House in discussion of the proposed Medicare program which has now become Public Law 89-97, a law which is anticipated to produce profound changes in the practice of medicine. The House convened on Sunday afternoon, reference committee hearings were held on Sunday night, and the House adjourned Wednesday evening rather than on Thursday, an innovation from previous years.

We were pleased by the cooperation of the delegates in presenting most of the 40 resolutions by title only, thus conserving vital time for the House. In a few instances, at the 1965 session, a delegate did not rise to formally introduce a resolution that had previously been submitted by a county society. The Speaker accepted these resolutions without objection from the House although the bylaws state that each resolution must be formally introduced at the opening session of the House. However, at the 1966 session, failure to introduce a resolution will be considered as a withdrawal of the previously submitted resolution and a desire that no action be taken regarding it. If a delegate is unable to present the resolution, the trustee of the district or another delegate may introduce it.

Reference Committees

The reference committees handle their work in an efficient manner. However, an unusual number of substitutions of reference committee members and tellers was required at the last minute, resulting in some confusion. A list of alternate members for reference committees will be prepared and available for the 1966 meeting. The trustees have been given an opportunity to submit suggestions for committee appointments. The reference committee hearings were conducted effectively, reports were written on time, and through the fine cooperation of staff, the reports were available in adequate time for presentation to the House of Delegates. Actions of the 1965 meeting were referred to the Board of Trustees and proper committees for implementation.

The effort to develop an improved method of preparation and presentation of reference committee reports was not entirely successful. A further attempt will be made in 1966 to acquaint all of the committee chairmen with the suggested procedure. Attendance of all of the chairmen at the briefing session is extremely important for an efficient operation of the work of the reference committees.

Committee on Constitution and Bylaws

In the past, it has been difficult to secure a list of delegates as early as desired. We have suggested to the Committee on Constitution and Bylaws that a proposed change in the bylaws be made to elect all delegates by December 31 of the preceding year. Such an action should facilitate early appointment of reference committees.

Again, we want to urge county societies to submit resolutions as early as possible. Resolutions receive more intelligent consideration by other county societies when they are submitted in sufficient time to be published in the April issue of the Illinois Medical Journal.

A permanent manual published in 1965, is being revised and should be in the hands of each delegate in time for thorough study before coming to the meeting. This revised manual will include parliamentary material and all pertinent information regarding the House of Delegates and reference committees.

The new procedure for presentation of nominations for election of officers and elective committees was successful in conserving valuable time and will be repeated in 1966, unless there is objection.

1966 House of Delegates

The format of the 1966 meeting of the House of Delegates will be similar to that of 1965 with the first session on Sunday afternoon, May 15, and adjournment late on Wednesday afternoon. An efficient and effective meeting

depends to a great extent upon following a previously arranged agenda and not adding additional items other than those of an emergency nature. When sessions extend beyond the expected time, delegates become fatigued, lose interest in the proceedings, do not give their undivided attention to the business before them, and in many instances leave the meeting before adjournment. Every effort will be made at the 1966 House of Delegates meeting to follow the announced agenda as closely as possible.

It has been recommended that trustees meet with the delegates from their district before the House convenes on Sunday afternoon for the purpose of reviewing resolutions and other business to come before the House.

A registered parliamentarian, who is a member of our society, has offered his services to serve as parliamentarian at the 1966 meeting. The Speakers welcome the opportunity of having such expert consultation available.

A statement has been made by the president of one of the larger, downstate county societies, who is not a delegate, that "it seemed apparent that the actions taken by the House of Delegates did not reflect the feelings of our membership, and did not appear to be in the best interest of medicine and/or the individual practitioner." Remarks have also been made from another source that some actions have been "railroaded" through the House of Delegates. Although we do not seek compulsory unanimity of opinion among a body of free professional men, we do most earnestly hope for and anticipate a cordial, enthusiastic, and sincere support of the majority decision of the members of our House. The Speakers will continue to exert every effort to allow full discussion before the House consistent with the rules adopted by the delegates at the opening session. Your Speakers believe that the reference committee hearings and the deliberations of the House constitute a remarkable example of democratic thought in action and will always welcome constructive criticism and suggestions directed toward improving the efficiency and effectiveness of the House of Delegates.

Edward W. Cannady, *Speaker*
Maurice M. Hoeltgen, *Vice Speaker*

PRESIDENT OF THE WOMAN'S AUXILIARY
AO-6

"The Person who Cares—Shares" has been the guiding phrase of the Woman's Auxiliary to the Illinois State Medical Society this past year.

The members have been active in community projects as well as auxiliary projects. It is very heart-warming to learn that the various counties have improved the image of the doctor and his family throughout the State. Auxiliary members have been instrumental in organizing eye clinics and mental health groups, in encouraging others to visit the aged and in informing people in regard to legislation. They have staffed fair booths, and given numerous hours to hospital auxiliaries and to volunteering.

Through the efforts of the auxiliary members, more than $1,000 has been contributed to AMA—ERF through the sales of charms, cheese, Christmas cards, etc. A total of about $7,000 has been contributed to the Benevolence Fund through dues and donations.

Ever mindful of the dire need for allied health careers, the auxiliary has sponsored future nurses clubs throughout the state and provided 18 scholarships for needy students.

Realizing the importance of all committees, each chairman has worked diligently in furthering the aims of the auxiliary.

The enthusiasm for the auxiliary and its projects has been gratifying. The biggest disappointment was in membership. Unfortunately, the goal of doubling the membership did not materialize. The doctors should continue to urge their wives to join. Maybe one solution to this problem would be team membership.

The President, as chairman, with 10 delegates and alternates attended the AMA convention in New York. The roster was compiled with the assistance of the corresponding secretary. Articles were written for the Illinois Medical Journal, the Chicago Medical Bulletin and the Pulse. Numerous letters were sent to officers, councilors, chairmen of standing committees, county presidents and the advisory committee.

The meaning of auxiliary and its projects, hopes and aims were presented at all 11 district meetings. These meetings were well attended. The councilors provided excellent programs and the discussions were stimulating.

The fall conference for state presidents and presidents-elect was attended in Chicago. This year an AMA regional workshop was instituted. The material received helped to make the auxiliary year more productive.

Other meetings attended are as follows:

1) Planning meeting with Mr. Richards.
2) Public Affairs Meeting.
3) Two convention planning meetings.
4) Community Service Meeting of the Third District.
5) About 20 county meetings.
6) The budget meeting.

7) Meetings with the social chairman in regard to board meetings.

8) Meetings with the various chairmen pertaining to their duties.

Presided at the post convention board meeting, fall and spring board meetings, pre-convention board meeting and one executive board meeting with the advisory committee.

This officer does care and she is ever grateful for the cooperation extended to her by the Illinois State Medical Society, the advisory committee, the efficient office staff and the officers and members of the auxiliary.

It was a privilege and a pleasure to share these experiences.

Mrs. John W. Koenig, *President*

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY
AO-7

The Advisory Committee had the pleasure of meeting with the officers of the Woman's Auxiliary on October 24, 1965. Since that time, there has been correspondence on important items of business, and insofar as we are able to determine, the Advisory Committee has served the Woman's Auxiliary in an adequate fashion during this past year.

After some discussion, the Advisory Committee sponsored a resolution before the Board of Trustees suggesting a joint husband-wife membership. This resolution has been supported by the Board of Trustees, and will be introduced at the House of Delegates as Resolution 66M-7.

The Advisory Committee has made suggestions to the auxiliary regarding convention speakers and district meetings which are proposed for 1966.

A modification has been recommended in the state society's newsletter entitled, PULSE, in order to provide more adequate recognition of the auxiliary projects.

The Advisory Committee, through the services of the staff, continues to provide administrative services as arranged for in previous years. This includes the production of auxiliary materials for the convention, their handbook, annual roster, board agenda materials, and provision for mailings when requested.

We would like to compliment the officers of the auxiliary for their very fine contributions to AMA-ERF, medical benevolence, and other projects which they supported for the state medical society.

Caesar Portes, *Chairman*
William E. Adams Burtis E. Montgomery
Ex-officio: Robert L. Richards

CHAIRMAN OF THE BOARD OF TRUSTEES
AO-8

In my report to the House of Delegates for 1966, it is my intention to cover only those items considered by the Board of Trustees which have no close connection with any established committee, either of the House or of the Board. The committees reporting to the House undoubtedly will include all items of major importance and/or any request for policy action in their reports.

My personal activities during this year have included many hours in meetings of the Board of Trustees and its key committees. The Executive Administrator and I have been in constant contact on every major activity, including his administration of staff responsibilities. A listing of my attendance at important meetings and committee sessions is being filed with this report and will be made available to the reference committee, if so desired.

Minutes of the meetings of the Board of Trustees have been made available to all delegates and officers of the county medical societies since November, 1965. Prior to that time a summary of the minutes had been mailed and also published in the Illinois Medical Journal. It is the wish of the Board of Trustees that the House of Delegates express itself as to whether or not the full minutes of Board meetings should be made available in the future. Under our present duplicating and mailing procedures the relative cost of both procedures is virtually the same and will make little difference, if any, in the budget for future years.

Because of the wide distribution of Board actions, this report is limited in content and does not enumerate each specific action taken by the Board during the year. The record of actions is accurately maintained in the headquarters office and any questions will be promptly answered.

Committee Appointments

An outline of the procedure used in the appointment of committees originating in the Board of Trustees might be of considerable interest and assistance to delegates.

Each trustee is asked to submit a list of the physicians in his district, together with the subject in which each is interested. The trustee must be reasonably sure that those physicians he recommends will be willing to spend the necessary time, are interested in the subject at hand, and can contribute to the group thinking and responsibilities involved.

Representation from all trustee districts is essential—not on each committee, but on an over-all basis. The fact that Chicago Medi-

cal Society represents about three-fifths of the total membership of the Illinois State Medical Society also is taken into consideration.

After suggestions are made and the chairman has developed the list of appointments, the material is mailed to all members of the Board for their consideration. Final action on committee appointments is taken at the next meeting of the Board—usually in July of each year.

A list of physicians willing to serve and not yet appointed to any committee, is maintained in the headquarters office for the convenience of the Chairman of the Board when vacancies occur during the year. This list usually includes the subject in which the physician is interested, and any additional information furnished by the trustee.

Cooperation With Other Groups

The importance of liaison with paramedical groups has never been more obvious. The friends of medicine among professional people need cultivation, encouragement, cooperation and close allegiance. The organization of the Illinois Association of Professions was a step in this direction, but more physicians must affiliate and must work to cement these new areas of contact. The Illinois Society of C.P.A.'s has been added to this group during 1965. We must extend support and friendship before we can expect reciprocal action.

The Board of Trustees has recognized this problem, and at the request of the Director of the Department of Public Health, contributed $500 to the annual meeting of the American Public Health Association held in Chicago October 18-23, 1965. This money was for the local group to act as host at the 93rd convention.

Dr. George F. Lull was recipient of the award given by the Interprofessional Council, and Dr. Andrew J. Brislen serves this group as president at this time.

The Chicago Convention Bureau presented the Illinois delegation to the AMA with a fine plaque at the New York meeting of the AMA, thanking the group for its continued work to present Chicago as an outstanding convention city, and to encourage the House of Delegates of the AMA to hold its meetings in this city at least every fourth year.

The ISMS, through its Liaison Committee to the Illinois Pharmaceutical Association, is working to develop a "Code of Interprofessional Relationship" between the two professions.

The headquarters office is trying in every way possible to cooperate with the various specialty groups, with emphasis on the hospital based specialties involved under PL 89-97.

The planning of the annual convention has included close cooperation with various scientific organizations which will hold meetings with us while we are in session at the Sherman House this May.

We call these activities to your attention and urge that you participate individually in every way possible, and work to develop similar liaison at the county level.

Advisory Committee to Selective Service

Unfortunately, it has been necessary to reactivate the Advisory Committee to Selective Service, and you will find an annual report of this committee submitted by Dr. Carl F. Steinhoff as the chairman. The functions of this committee are to assist the Advisory Committee appointed by the United States Government to maintain the medical requirements in Illinois communities, to see that our medical schools are adequately staffed, and to furnish the necessary number of physicians for our armed forces. Doctor Steinhoff's long experience makes him the one physician unquestionably qualified to chair this committee, and assures the physicians and the communities of unbiased opinion and assistance.

Use of Legal Counsel

It is the responsibility of the officers, particularly the Chairman of the Board, to work closely with the Executive Administrator "to advise and assist" any county medical societies requesting legal counsel.

The Illinois State Medical Society may not furnish legal counsel to any individual physician, since this constitutes the practice of law by a corporation, and is unethical. Therefore, before our legal counsel can render an opinion, the request must be screened relative to source, the question involved, etc.

The Board of Trustees has ruled that any request for assistance in the legal field must be submitted to the Executive Administrator prior to being referred to the legal counsel. If there is any doubt relative to the advisability of asking our attorney to research the problem and render an opinion, Mr. Richards has the opportunity to consult with the officers and/or the trustees for the protection of the society and the conservation of society funds.

Our legal counsel has reviewed the malpractice suit against an Illinois hospital which resulted in a judgment of $110,000 against the hospital, and $40,000 against a physician. This suit may well establish the liability of the hospital in cases based upon negligence on the part of a physician. We have asked our legal counsel to keep a close watch on this case and submit his opinion which has been sent to all county medical societies for their information.

At the last Board meeting the legal counsel stressed the fact that committee activity pertaining to business firms, and to the criticism of any product, should clear legal counsel prior to any correspondence being mailed or any criticism being printed.

Any county medical society developing a new constitution and/or bylaws, has the opportunity to consult our committee, and then to have the county medical society manuscript checked by special legal counsel prior to publication to make sure that it does not conflict with either the Constitution and Bylaws of the American Medical Association or that of the state society.

Staff Planning Conference

A staff planning session was held at Oak Brook August 6, 7, and 8, 1965. The Board of Trustees felt that the contributions which might result from such a conference warranted the expense involved. Members of the staff spent three days discussing proposed activities in each of the divisional areas. A professional consultant was authorized to assist in organizing the series of proposals which culminated in a study to be submitted to the Board for its consideration.

While it may be years before all the suggested programs discussed and outlined by members of staff can be put into effect, the material accumulated and prepared in usable form will furnish the basis for planning committee considerations for some years.

The Executive Committee feels that this material could be turned over to a planning committee to study and to use as the basis for proposed new activities and new programs which would be of inestimable value to the membership of the society, and will help maintain the Illinois State Medical Society's position as one of the outstanding medical societies in the country.

Procedures of Board of Trustees

The Board of Trustees has become an open forum—a sounding board for committee programs and reports, and a clearing house for society activities. The time devoted to meetings of the Board has been extended and sessions are held both on Saturday evening and Sunday morning. Both sessions are attended by AMA delegates, officers and Board members. The serious considerations by the Board of problems which involve a million dollar a year business are obvious and our method of operation is generally as follows:

The Sunday session provides committee chairmen and special guests an opportunity to present progress reports and familiarize themselves with important actions.

The Saturday night meeting is by "invitation only," with a specific request for Board action on the agenda.

It is hoped that length of reports will be limited; the amount of time allocated for progress material will be curtailed and anyone presenting a written report will be asked not to read it in detail in order to conserve time and maintain efficiency.

Any new program involving the expenditure of money which comes before the Board and not previously included in the budget, is presently being referred to the Finance Committee for recommendation.

Reports of Directors of Public Health, D.P.A., Mental Health, Vocational Rehabilitation

In order to provide the House with up-to-date information on the activities of the departments of government which relate to medical offices in the State of Illinois, we invite to attend our Board meetings the directors of the above listed departments and divisions. Appended to this report are statements from each which will provide to the reader a better understanding of what they are presently doing and their plans for the immediate future (see Appendices A, B, C, and D).

Items Referred to the Board by the 1965 House of Delegates

Resolution 65-M-14 entitled: "Liberalization of Abortion Laws" was referred by the Board of Trustees to the Maternal Welfare Committee. A specific report covering this item will be found in the report of that committee.

The House of Delegates suggested that the Board look further into the possibility of combining medical journals with those of surrounding states. Correspondence with the states of Wisconsin, Michigan and Indiana has indicated no interest on the part of these associations to combine.

The House of Delegates concurred with the suggestion that a direct dues billing program might be initiated with county medical societies. In addition to this effort, which has been effected in over 50 county medical societies, it has been possible to establish an IBM procedure which will make available to our committees, and to our Board accurate statistical information regarding our membership. Further information on this procedure will be contained in the report of the Secretary-Treasurer.

The House of Delegates referred to the Board a suggestion that the committees of the society should be carefully studied and analyzed with respect to their functions and delineations of responsibilities and membership. During the current year, the Commit-

tee to Study Committees, made up of Board members, has carefully studied the committee structure. A report by this committee and the recommendations concurred in by the Board of Trustees will be submitted to the House of Delegates.

Opinion Research Study

For several years through various reports of reference committees, and through comments by individual members of the House of Delegates, it was intimated that the Board of Trustees should look carefully at the time, money and effort expended by the society, and to ascertain the general direction in which the society should make its efforts felt. In conjunction with the staff planning conference mentioned previously in this report, the Executive Administrator at the October 23, 1965, meeting recommended that Opinion Research Corporation be employed to conduct a membership survey in order to ascertain: 1) the membership reaction to the present program of the state society, and 2) to determine wherein the efforts of the society might best be spent in the future years. The Board of Trustees adopted this recommendation, and authorized Opinion Research Corporation to carry out a study in depth, and to present its findings at the May, 1966, meeting of the House of Delegates. A preliminary report will be seen by the Board of Trustees at its March meeting, but the entire report and results of the study will be presented to the House of Delegates by a representative of Opinion Research Corporation. The Board of Trustees looks forward with anticipation to the help which we hope to secure from the results of this survey which we believe will represent general membership opinion. It is our anticipation that the future course of our activities will be largely determined by the results presented at that time.

Budget for 1966 and 1967

The budget for the year 1966 and 1967 has been presented to the Board of Trustees by its Finance Committee. We are presently operating on the basis of the 1966 budget which provides for all items recommended by the Reference Committee on Administrative Activities in its report to the 1965 House of Delegates. The details of the 1966 and anticipated 1967 budget will be made available to the members of the Reference Committee well in advance of their initial meeting. Along with this information will be included the budgets of the Medical Benevolence Committee, the Educational & Scientific Foundation, and the allocations which have been made to special funds such as AMA-ERF, IMPAC, etc. It is anticipated that the Chairman of the Finance Committee will comment on the budget at the first session of the House of Delegates. A copy of the audit for the year 1965 will be included in the packet of material made available to each delegate.

Additional Activities of the Board not otherwise reported by Committee Reports, and listed as follows for the information of the House of Delegates

1. Every fourth year the AMA meets for its annual convention in Chicago. The Board has actively pursued the formation of an appropriate committee with sub-committees to make arrangements for all the details concerning the meeting scheduled for June 26-30, 1966. Dr. Noel Shaw of CMS, and Dr. B. E. Montgomery of Harrisburg, are serving as Chairman and Co-Chairman of the Local Arrangements Committee.

2. The Board of Trustees has endorsed the general principles and policies enunciated by the AMA regarding its co-operative endeavor in the implementation of P.L. 89-97, or Medicare, as it is commonly called. The policies enunciated and the discussions of usual and customary fees, the determination of criteria for utilization committees, and all other ramifications of this law will appear in reports of other committees. However, the Board has designated an ad hoc committee to deal with the complex problem of establishing usual and customary fees with respect to all governmental programs. We feel that the House of Delegates should know that this special committee has been authorized to request the use of professional and experienced negotiators as was recommended, if necessary, by the House of Delegates at its previous meeting. Details of this activity will be found in the report of the Ad Hoc Committee on Usual and Customary Fees.

3. Consistent with our policy of keeping the delegates informed, and advising them of resolutions and reports which will come before them, we have this year instituted an arrangement whereby trustees of the eleven districts may schedule in advance of the opening of the House of Delegates an informal conference with the delegates from their districts. Although this is not mandatory, it is hoped that the delegates from county medical societies will cooperate with their trustee in attending these scheduled meetings. If for any reason your trustee has not scheduled such a meeting, or you are unable to attend, it is suggested that you contact him and express your opinion on the reports contained in this issue of the Journal, and any other request which you may have to present, especially any resolutions which your county society has asked you to introduce.

4. Your Board of Trustees continues to be effective in recommending members for appointment to governmental commissions, committees, and important positions in other organizations which assisted organized medicine in its cause. We are listing here those physicians who have been appointed to these governmental units and organizations:

Illinois Air Pollution Control Board—
Thomas J. Kelly, M.D.

Commission to Survey & Study the Public Health Needs, Services, Resources & Facilities in this State—
Henrietta Herbolsheimer, M.D.
Harold A. Sofield, M.D.

Citizens' Advisory Committee on the War on Poverty—
C. K. Wells, M.D.

Committees of the Chamber of Commerce of the U. S.
Policy—Philip Thomsen, M.D.
Membership—Jacob E. Reisch, M.D.
Associations—Robert L. Richards

Narcotics Advisory Council—
Joseph H. Skom, M.D.

Clinical Laboratory & Blood Bank Advisory Board—
Paul A. Van Pernis, M.D.
H. P. Dexheimer, M.D.

Advisory Council to the Federal Heart, Cancer & Stroke Regional Medical Program
B. E. Montgomery, M.D.

5. It has been customary for the Board of Trustees to meet annually with the Deans of Medical Schools. Such a meeting is scheduled for the evening of March 11, 1966, after the preparation of this report. We know that they have been cooperating with us in the work of our Committee on Medical Education. They have provided to us information regarding the use of money made available to them via the AMA-ERF, as well as other information which we have requested during the past year.

The Chairman of the Board of Trustees would like to express his sincere appreciation to the Officers of the Board, AMA Delegates and Alternate Delegates, and Committee Chairmen, as well as the members of the House of Delegates for their cooperation during the past two years during which I have served as Chairman of the Board. I know that the Trustees and staff members will avail themselves of every opportunity they have to be of service to you as Delegates during the Annual Meeting. My personal gratitude is extended especially to President Montgomery, and the Executive Administrator, Mr. Richards, and his staff.

William E. Adams,
Chairman of the Board of Trustees

APPENDIX A

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Dr. William Adams, Chairman of the Board of Trustees, has invited me to report on future programs, especially those which might require the cooperation of the Illinois State Medical Society and practicing physicians. It would be appropriate to begin this report by stating that you will find elsewhere in the House of Delegates material, reports of the Department of Public Health activities during the past year. It is also appropriate to consider that 1965 represents a hinge of history in the health area. Public Law 89-97 (the 1965 amendments to the Social Security Act) and other newly enacted federal and state laws will be long remembered for their impact on future health programs.

I. Public Law 89-97 (Medicare).

A. Increased benefits for maternal and child health and crippled children's programs. (Title II).

B. Certification of hospitals, extended care services, home health services and laboratories to the Secretary of the Department of Health, Education and Welfare as providers of service for Medicare recipients. This authority was vested by Governor Kerner in the Department of Public Health. (Title XVIII).

C. Medical assistance programs. To provide a more effective program of medical care for needy persons there is established a single and separate medical care program which improves and expands various provisions for the needy previously covered under five different titles of the Social Security Act. Implementation of these Title XIX programs was begun January 1, 1966, by the Department of Public Aid (ISMS has recommended that the administration of Title XIX be placed under the Department of Public Health).

II. Public Law 89-239. The Heart, Cancer and Stroke Regional Medical Programs. Governor Kerner appointed the Director of Public Health as Chairman of his committee to coordinate this program for the State of Illinois with representation from the Illinois State Medical Society, medical schools, hospitals, local official health agencies, voluntary health agencies, labor, and public representatives.

III. Health activities under the Economic Opportunity Act. Especially in urban areas there are programs under the so-called "poverty act" which will require close cooperation between state and local health departments and the state and local medical societies.

IV. In addition to the important health programs for fiscal year 1966 (not all herein mentioned) there is a program in the President's budget for fiscal year 1967 providing for planning grants to state health departments. A new and important relationship between the physician as captain of the health team and the official health agency of the state will bring a new systems oriented study of the organization and delivery of preventive medical and medical care services. This will include planning for accelerated urban hospital modernization and increased opportunity for training in the medical and allied health professions and services. To date no single agency has had direct knowledge of the various facets of health programs in our state.

V. The Illinois State Medical Society has during the past year testified at the Conference on the Pollution of the Interstate Waters of the Grand Calumet River, Little Calumet River, Calumet River, Wolf Lake, Lake Michigan and Their Tributaries. This testimony was in favor of preserving the quality of water as a natural resource for the entire population in this midwest area. This program is ongoing and will require continued participation by organized medicine in a several state area to insure that water pollution control is achieved before irreversible changes occur in the southern Lake Michigan area. It is important to recall that the Great Lakes area of the United States and Canada is the greatest concentration of fresh water on the earth. Under the general program of restoring the quality of our environment we must work closely together in air pollution control, radiation health and proper use of insecticides, fungicides and fertilizers. The Illinois Department of Public Health has also been appointed to coordinate disposal of solid waste, another growing problem in our state.

VI. Animal-health relationships are essential to our future survival in an increasingly complex relationship of the ecology of man, animal and many other more primitive forms of life.

VII. The Governor approved legislation to establish a Public Health Study and Survey Commission to determine the availability, adequacy, organization and distribution of public health services and environmental health facilities; costs and methods of financing; statutes relating to public health; and the public health needs of the State. The Commission has initiated its study by requesting from knowledgeable individuals and agencies, including the Illinois State Medical Society, opinions concerning the major public health needs in the State of Illinois.

VIII. Other significant programs which have recently been established in which a close working relationship exists with the Illinois State Medical Society are the phenylketonuria program and the accidental death-blood alcohol program.

In summary, it can be said that service to mankind as a member of the health professions is becoming increasingly important in our exceedingly complex life. Without dwelling on the precarious world wide power conflicts it can perhaps be said that in a large sense if mankind is to survive we must pay increasing attention to the economic effects of health and as peace hopefully becomes increasingly secure, more of our gross national product can be directed toward the important goal of increasing the quality of our health and living.

Franklin D. Yoder, *Director*

APPENDIX B

DEPARTMENT OF PUBLIC AID

About 400,000 persons in Illinois receive some form of public assistance. About one-half of these are children; about one-fourth are aged, blind or disabled and the remaining one-fourth are adults who are divided about evenly among those who have a good potential for employment and those who do not.

About $24 million each month is distributed to these recipients or paid in their behalf to providers of services. Of this $24 million about $7 million is for medical services. We have provided a rather comprehensive program of medical care and rehabilitation for eligibles who are sick and disabled and for the past quarter century, we have worked closely with the medical profession in the formulation of our policies and the development of medical services.

Illinois has submitted a plan to the Department of Health, Education and Welfare for implementation of Title XIX of Public Law 89-97. On the basis of generally favorable reactions during preliminary discussions, we embarked upon the Title XIX program effective January 1, 1966. The comprehensive program of medical assistance is now available for an increased number of eligibles.

A new Division of Medical Services has been established under the direction of a full time Medical Director. Staff will be added as required in the several professional areas. It is our desire to continue our excellent relationships with the Illinois Medical Society and with the county medical societies throughout the State. We will continue also, our cooperative relationships with the State Department of Public Health and with other departments of State government with whom we have mutual interests and responsibilities.

The Department of Public Aid has taken the

position that programs of preventive medical care should be the primary concern of the State Department of Public Health and should be available to all segments of the population including those eligible for public assistance. Our thinking and our support of such an expansion of Public Health's responsibilities are known to the Director of the State Department of Public Health and are items of current discussions. If such broadening of responsibilities of the Department of Public Health cannot be accomplished, the Department of Public Aid is prepared to establish plans for a preventive medical program.

Similarly, the Department of Public Aid has encouraged the expansion of responsibilities for the State Department of Mental Health to provide psychiatric and other services for those in need of treatment for mental conditions. Such treatment, as we see it, should be provided by a single State agency, namely the Illinois Department of Mental Health. However, if adequate programs for the entire population are not possible by this approach, the Department of Public Aid will establish plans to provide necessary services for those eligible for public aid.

It is quite apparent that the philosophy and mechanics of payments to providers of services under existing State welfare programs will need to be reviewed and modified as a result of the implementation of Title XVIII. The Department of Health, Education, and Welfare has indicated that States operating under Title XIX must establish a realistic schedule of compensation for all services and while few specific instructions have been issued as yet, there are indications that this "realistic schedule of compensation" should be fairly closely related to "the reasonable costs or reasonable charge within the community."

In Illinois, we have ongoing discussions with representatives of the State Medical Society, the nursing home industry, hospital groups and other providers of medical services considering the problem of payment. To illustrate the problem areas which we must consider, I might mention the fact that in Illinois we pay only 98% of the net billings from a hospital; and each year we claim credits if billings have been in excess of costs. This approach may not align with the Federal policy on payments under Title XVIII.

We pay only $3 to a physician for an office visit which probably will not align very well with rates which will be authorized under Title XVIII. Nursing homes have presented cost analyses indicating that payments in behalf of public assistance patients barely meet the costs of operations and in some instances produce losses which are offset only because higher rates are charged those patients with an independent ability to pay.

In all these areas—and in others not enumerated—it will be necessary for adjustments to be made under the Illinois Title XIX program. We believe that during 1966 the solution of many of these problems will be found. In seeking solutions, we will consult with representatives of all segments of the medical field.

Harold O. Swank, *Director*

APPENDIX C

ILLINOIS DEPARTMENT OF MENTAL HEALTH

During 1965, patient population at Department of Mental Health facilities continued to decline in the face of rising admission rates. The decline of 2,073 in patient population at state hospitals during the year was the sharpest in the history of the Department. Patient population now is 30,821. The decline came in the face of hospital admissions that totalled 19,890, a new high. The previous year, admissions totalled 17,844. Discharges were also up. In 1965, total discharges were 18,825 in place of 15,479 the previous year.

The decline in hospital population began in 1955 and accelerated in 1963. It is generally attributed to tranquilizing drugs, a growing recognition that many mentally ill persons can be treated as out-patients living at home, and a variety of short-term intensive treatment techniques made possible by larger staffs and budgets.

At the present time, in seven of the state's 11 hospitals, unit systems are in full operation or in advanced planning. The seven are: Anna, East Moline, Galesburg Research, Elgin, Jacksonville, Peoria and Chicago State Hospitals.

The unit system split large, unwieldy institutions into smaller, semi-autonomous treatment units. Each unit has its own staff team composed of physicians, psychologists, social workers, activity therapists, psychiatric aides and others.

Two other hospitals—Alton and Manteno—have unit systems under discussion and have taken initial steps toward adopting them. Most of the effort toward development of unit systems has taken place during the past four years.

During 1965, three Department facilities received National Institute of Mental Health employee training grants. The three were: Manteno State Hospital, Warren G. Murray Children's Center in Centralia and Galesburg State Research Hospital. Each grant is about $25,000 a year, renewable for five years at least.

Manteno's project will train psychiatric

aides in milieu therapy; Murray Center will have child care aides take courses at Centralia Junior College for two year associate degrees; and Galesburg will train child care aides within its child and adolescent treatment unit.

NIMH training grants for psychiatric aides awarded to Jacksonville and Kankakee State Hospitals in 1964 have been renewed. Grant applications for 1966 have been sent to NIMH by 10 other Department facilities.

Matching progress in existing facilities, the Department's zone program continues to progress. The first zone center, Charles F. Read in Chicago, opened in July. In spring, summer and early autumn, centers in Maywood, Rockford, Peoria, Decatur, Champaign and Peoria will open. In short, all of the state's comprehensive community mental health centers, except Springfield, will be in operation during 1966. Zone directors and staff for each of the centers, with the exception of Springfield, have moved into temporary quarters to plan programs and make initial community contacts while awaiting completion of their centers.

Complementing zone center programs are recently issued state plans for federal construction funds for both mental health community centers and community mental retardation facilities. Applications for these centers are now being accepted. Meanwhile, the Department has established a permanent planning division made up of the staff of the Planning and Evaluation Services. The staff is completing the state's mental health progress report.

In other community activities, the Department continues to give grants-in-aid to some 50 community mental health clinics and 30 day care centers for the retarded. The grants for 1965 totalled more than $3 million.

During the past year, the William Fox Children's Center, formerly Dwight Veterans' Administration Hospital, opened as a Department facility for physically handicapped, mentally retarded children. The center accommodates 250 children ranging in age from six to 15.

Early in 1966, another Department mental retardation facility, the A. L. Bowen Children's Center in Harrisburg, began operation. The 250-bed facility is the Department's newest retardation center.

In the state's other retardation facilities—Lincoln and Dixon State Schools, plus the Murray Center in Centralia—1965 saw a slight increase in patient population. The total was 9,990, an increase of 82.

To emphasize community centering of mental retardation services, assistant zone directors for mental retardation have been appointed in five of the state's eight zones.

Under a vigorous recruiting program, Department staff continued to increase. During 1965, staff in Mental Health, the state's largest code department, passed the 18,000 figure. Department operating budget, approximately $150 million a year, is the largest in Department history.

Harold M. Visotsky, *Director*

APPENDIX D

ILLINOIS DIVISION OF VOCATIONAL REHABILITATION

Advisory and direct service involvement of the medical profession in the state program of vocational rehabilitation, already substantial, will expand greatly as DVR/ILLINOIS responds to the challenges contained in Public Law 89-333, the Federal Vocational Rehabilitation Act Amendments of 1965.

Implicit or expressed in every line of the law and supportive federal rules and regulations is a mandate to develop and implement a plan of action assuring prompt and proper service to all eligible disabled-and-vocationally-handicapped persons in Illinois.

Target date for realization of this ambitious objective is 1975. Governor Otto Kerner has designated the Board of Vocational Education and Rehabilitation as the state agency to undertake, through its Division of Vocational Rehabilitation, the challenging task of comprehensive statewide planning and related effort involved.

The mechanism for moving toward this objective is now being developed. Provisions for full federal funding of the planning effort, up to a maximum of $100,000 per year for three years, stipulate that it "*must include, or utilize an Advisory Committee that includes, representatives of the State legislature . . . ; labor, management; medical and health-related organizations and institutions; the Governor's Committee on Employment of the Handicapped; education; the public and voluntary agencies providing rehabilitation services to the physically and mentally handicapped and other appropriate public agencies and civic groups interested in the development of rehabilitation services.*"

Concurrent with and linked to this overall planning effort will be a special project, financed jointly by state and federal funds, "to make an initial determination of the State's needs for workshops and rehabilitation facilities, and to provide for a continuing program for assessing such needs and evaluating activities for establishment, construction, utilization, development and improvement of workshop and rehabilitation facilities."

The advisory and consultative involvements of the medical and related professions in the planning and implementation aspects of these

efforts are recognized by all concerned with organizing the statewide comprehensive planning program. In significant and substantial degree, rehabilitation services and facilities will find their capacity for effective expansion and growth enhanced tremendously by the advisory contributions of the medical profession.

The direct service involvements of the medical profession are also significantly increased under other provisions of the Vocational Rehabilitation Act as amended.

Perhaps the most significant and far-reaching change in this connection is in the determination of rehabilitation potential.

To qualify for the full range of vocational rehabilitation services, an individual must (a) have a physical or mental disability which constitutes a substantial handicap to employment and (b) vocational rehabilitation services rendered should reasonably be expected to render the individual fit to engage in a gainful occupation.

Prior to the 1965 amendments, the judgment demanded in (b) above often, and of necessity, had to be based upon insufficient evidence. Now, where the disability and handicap to employment are established, but there is inability to make a determination of potential without an extended evaluation, provisions are made for utilizing the full range of rehabilitation services that would be helpful in determination of potential.

For this purpose, "necessary vocational rehabilitation services . . . may be provided during a period not in excess of 18 months in the case of an individual whose disability is (1) mental retardation, (2) deafness, (3) blindness, (4) paraplegia, quadraplegia and other spinal cord injuries or diseases, (5) heart disease, (6) cancer, (7) stroke, (8) epilepsy, (9) mental illness, (10) cerebral palsy, or (11) brain damage, and not in excess of 6 months in the case of an individual with any other disability."

Indicating the scope of services permitted for this purpose: ". . . any or all of the following vocational rehabilitation services shall be provided if necessary to determine the rehabilitation potential of the individual: (1) Diagnostic and related services; (2) physical restoration services (without the need for a determination that the physical or mental condition is stable or slowly progressive); (3) maintenance; (4) transportation; (5) training materials (including tools); (6) reader services for the blind; (7) interpreter services for the deaf; (8) comprehensive evaluation at a rehabilitation facility, workshop or other suitable facility; (9) other goods and services, as specified in 401.1 (x) (2), which are necessary to determine the rehabilitation potential."

(Note: all statements herein enclosed in quotation marks are excerpted from the federal rules and regulations revised pursuant to Public Law 89-333.)

Thus, the opportunity for members of the medical and related professions to contribute vastly expanded effort and evidence to the determination of rehabilitation potential offers hope for achievement of employability and employment potentials to an increasing number of the severely disabled.

Where the need for service is so great, the opportunity for service challenges the best efforts of the individuals and associations concerned. DVR/ILLINOIS most earnestly solicits and welcomes the help of the Illinois State Medical Society and its membership.

Alfred Slicer, *Director*

POLICY COMMITTEE AO-9

After the "Policy Manual" of the Illinois State Medical Society appeared in the December, 1965 issue of the *Illinois Medical Journal*, a few comments were received for the consideration of the committee.

We are adding a policy statement relative to PUBLIC HEALTH and another short statement based upon AMA policy relative to FAMILY PLANNING. They follow here for your consideration.

Public Health

The ISMS endorses the establishment, development and maintenance of county health units under the auspices of the State Department of Public Health. Whenever possible, such single or multiple county units should be set up for the protection of the citizens of Illinois, the prevention of epidemics and communicable diseases and for the performance of such duties as are normally attributed to public health authorities.

Programs sponsored by the State Department of Public Health should be cleared with the Board of Trustees, then approved by each individual county medical society in areas where the Department puts such activities into effect.

Family Planning

The prescription of child-spacing measures should be available to all patients who require them, consistent with their creed and mores, whether they obtain their medical care through private physicians or tax or community-supported health services.

Modification of Statement Regarding Examinations

The Occupational Health Committee of the Illinois State Medical Society met and con-

sidered the policy manual in detail recently and addressed a letter to our consideration dealing with a modification of the general statement regarding examinations in a physician's office. This statement was developed by the Policy Committee to deal with problems such as that presented by the immunization program using Salk vaccine for poliomyelitis, etc. and no thought was given to the effect it might have upon the practice of industrial medicine within the plant or office. Therefore, we suggest that the following be added to the statement regarding "Examinations" as it appears in the Manual enclosed in your packet for the House.

"This general statement does not apply to the industrial or occupational health physician in his in-plant activities."

Then the statement would read:

"All physical examinations should be performed in the physician's office. No examinations shall be conducted on a group basis unless authorization has been given by the local county society in a single instance or for a specific purpose.

"This general statement does not apply to the industrial or occupational health physician in his in-plant activities."

Newton DuPuy, *Chairman*
Arthur F. Goodyear Frank J. Jirka

COMMITTEE TO STUDY COMMITTEES OA-10

The basic reason for the Committee on Committees holding an organizational meeting was the recommendation by the 1965 Reference Committee on Miscellaneous Business . . . "that the report of the Committee to Study Committees be accepted as one of information, and that serious consideration be given by the Board of Trustees to a bi-annual review of all society committees and their functions. This review would eliminate and consolidate overlapping activities and expenses . . ."

Dr. H. Close Hesseltine, the first chairman of this Committee, was asked to meet with the group and to brief the members on the background, procedure, working methods, general thinking, and to submit his suggestions relative to future activities.

In 1962 there were 57 committees and eight representatives to other groups on the society records; in 1965 a published list of committees contained 62 committees and the office records showed about six or eight representatives to other groups.

Standing Committees

The following are Standing Committees of the House of Delegates (outlined in the Bylaws), but are appointed by the Board: Scientific Assembly, Medical Legal, Impartial Medical Testimony, Legislation, Public Relations, Medical Benevolence, Archives and Constitution and Bylaws; while the following, also Standing Committees, are elected by House action: Medical Education, Grievance, Prepayment Plans and Organizations, Disaster Medical Care, Laboratory Evaluation, Occupational Health and Public Safety. These Bylaws committees are supplemented by some 45 to 50 additional committees appointed annually by the Chairman, and approved by the Board of Trustees usually at the June meeting.

General Recommendations

Following the first meeting of the Committee on Committees, a series of general recommendations pertaining to all committees, was developed for presentation to the Board for its consideration and comment. The committee felt that these recommendations should apply regardless of the origin of the committee—House or Board:

(1) The purpose of the Committee to Study Committees should be to continuously consolidate and combine and develop the committee structure of the ISMS.

(2) Membership on Society committees should be composed of physicians definitely interested in the subject and willing to serve.

(3) Each physician should be limited to membership on one committee. He may be used as "consultant" for other committees if so requested, or as ex-officio member of others.

(4) Appointments to all committees should be staggered to assure continuity and any committee appointment or election for more than one year should be "reviewed and renewed" at the end of each year to assure active participation on the part of all members.

(5) Each chairman should report attendance at all committee meetings, and make recommendations for the evaluation of appointments in the future.

(6) The chairman should submit a proposed program for his committee, accompanied by a suggested budget and he should make sure that both the program and the budget are understood by all committee personnel.

(7) Every committee should have a vice-chairman to maintain continuity.

(8) All committees should hold their first meeting prior to January 1st.

(9) The number of physicians appointed to committees from any one Trustee District should be based upon the physician-population of that district—unless the question involved is geographic in nature.

(10) A classified backlog of physicians willing to serve on committees should be maintained from which appointments can be made as vacancies occur.

(11) Committees should be informed that they may NOT MAKE POLICY, but may recommend action to the Board for consideration until such time as the House of Delegates has an opportunity to act.

(12) Non members of ISMS may be appointed as consultants to important committees. This ruling may also apply to non-physicians who are involved in the work of the committee, or who are well informed on the subject under discussion.

(13) Representatives appointed by the Board and/or the House of Delegates to represent the society before other organizations, should report to a committee so that the report may be considered in proper context wherever possible. The report of an individual should not be rendered directly to the Board, but should come through an appropriate screening body.

(14) The committee felt that the length of time a physician should serve on any one committee should be limited—perhaps to a maximum of 9 years—with the total number of years so stated. After the term expires the physician may be used as consultant upon the request of the committee involved.

(15) No member of the "official family" (officers and trustees) shall have appointments on any committees other than committees within the Board. He may serve as consultant or in an ex-officio capacity however.

(16) The committee recommends that the Committee on Committees be included and its duties defined under the section of the Bylaws along with those of the Executive Committee, the Finance Committee, the Policy Committee, the Ethical Relations Committee and the Journal Committee—all of which are composed of Board of Trustees members only.

The Board accepted the report of this committee as a matter of information, and no Board action was taken.

The committee studied the duplication of appointments given to outstanding physicians throughout the state, and found it a rather serious situation. Based upon this information, the Committee on Committees felt that some control of multiple committee membership should be established for both House and Board committees, and that perhaps the House of Delegates might suggest a solution. The committee has recommended "one physician—one committee" with any further service on a consultant or ex-officio basis.

The committee also stressed the recommendation that a careful attendance record should be kept with a general ruling relative to unexcused absences. The distance involved for the physician to attend, his interest in the subject under consideration, and a possible conflict because of multiple committee appointments were considered.

The committee reported that perhaps the next step might be to take a "long look" at the committee structure, the functions of each committee, and try to develop some combination of existing committees based upon a logical approach (the functions involved or the subjects assigned). It also might be possible to extend the functions of some of the committees, and enlarge the membership of others to maintain a broad membership base, since the Committee on Committees did not want to subtract from the total number of physicians to be assigned to the work of the various society committees.

It was the opinion of the committee that much of the criticism of the officers, members of the Board of Trustees and key men in Society activities, could be avoided by the distribution of responsibility and the development of more interest through the involvement of additional committee personnel throughout the state.

William H. Schowengerdt, *Chairman*

Ted LeBoy — Jacob E. Reisch

Joseph R. O'Donnell — Charles K. Wells

ETHICAL RELATIONS
OA-11

The primary function of the Ethical Relations Committee is to serve as an appellate body to review cases of alleged misconduct referred to it by component societies or appealed by individual physicians. During the past year, the committee sat in judgment of appeals from two physicians.

On July 31, the committee sustained the action of the Chicago Medical Society in its expulsion of a member who subsequently appealed to the Ethical Relations Committee of the American Medical Association. As of this writing, we have not been informed of the AMA's action in the matter.

Then on February 10, the committee convened to hear a physician's appeal regarding his expulsion from the Chicago Medical Society. At the time of this report, the committee is in the process of developing its recommendation on this matter.

By personal contact and other communication, two other incidents have been satisfactorily resolved wherein the Narcotics Division of the State of Illinois had conducted an investigation of involved physicians.

It is felt that the Ethical Relations Committee may be called upon with greater frequency as the many forces influencing medical practice manifest themselves in the future. The current procedures outlined in Constitution and

Bylaws may be worthy of study and modification to facilitate and insure that due process prevails in the matters taken under study.

The committee also conducted its annual survey of county societies regarding the disposition of ethical relations cases on the local level. The survey—which drew responses from 45 county societies—showed that 10 other disputes were heard during the past year.

While seven of these 10 cases involved excessive fees all were settled through agreements between the physicians and patients. The others involved a charge of unprofessional conduct, an illegal operation, and cashing of a duplicate check from an insurance company. All were settled on the county level.

This does not reflect the entire story, however, since the Chicago Medical Society actually has three different committees screening complaints which otherwise might come before and be reported through the Ethical Relations Committee. Only those cases warranting the attention of the Ethical Relations Committee are referred to it, while others are disposed of by other committees.

Willard C. Scrivner, *Chairman*
J. Ernest Breed — Edward A. Piszczek
William E. Lees — Paul P. Youngberg

MEMBERSHIP COMMITTEE
AO-12

The ISMS Committee on Membership exists on an advisory basis to serve the county medical societies that request assistance in matters of medical society membership. Since ISMS Bylaws state that the county society shall be sole judge of the qualifications of a physician for membership in ISMS or the AMA through Illinois, the Membership Committee does not have the primary responsibility for increasing the membership of our society.

There has been no request for assistance of the Committee since the last meeting of the House of Delegates. Accordingly, no formal meeting of the Membership Committee has been held during the past year. The chairman of the committee has had several discussions with the staff Director of Business (membership) Services regarding communications between members and county societies and the ISMS office. Nothing has developed over the past year that could not be handled by the staff or the ISMS Secretary-Treasurer on the basis of previous policies. In this connection, the reader of this report is referred to the report of the Secretary-Treasurer for further information regarding ISMS membership statistics.

The ISMS Board of Trustees has requested that research be conducted on the number of ISMS members on each medical school faculty. The importance of developing substantial programming and committee activity directed toward the needs and problems of the physician in full-time teaching, administration or other activities is pointed up by the preliminary results of this research, which show that a number of physicians doing little or no private practice do not feel it necessary or desirable to belong to their state and county societies. Program materials along these lines may be developed and additional assistance can be provided by the society's staff, if it is desired by the county medical societies.

Apparently there are substantially over 2,000 licensed physicians in the state who are not members of a county medical society. According to our reports a good percentage could qualify. Most of these are located within Cook County. It is the committee's belief that there are meritorious reasons for activities directed toward increasing our membership.

H. Close Hesseltine, *Chairman*
W. C. Bornemeier — Harold E. Himwich
Casper Epsteen — Joseph O'Malley
H. D. Scott, Jr.





ADMINISTRATIVE REPORTS

SECRETARY-TREASURER
AF-1

Since the last meeting of the House of Delegates, the activities of the society have been at an all time high. As in the past, the implementation of the various directives of the House and the continuance of the society's established programs have consumed the greater portion of the staff's and board's time. Added to this have been such major projects as research and planning necessitated by the ever-expanding complexities of legislation affecting medicine, the informational needs of the membership concerning Medicare, the problems associated with the renewed physician military draft, and many other various services for the benefit of the membership.

During the year the image of the ISMS has been increased and enhanced in many ways by the activities and forward steps taken in public affairs and public relations. Today the voice of medicine in Illinois reaches more people in this state by radio, TV, newspaper and other mass media communication than at any previous time. Your alter ego, Dr. SIMS, has been everywhere and spoken well for you.

Only after all of the activities of the past year have been studied individually by the 1966 House and then assembled into a mosaic of 1965 will the true picture of what the Illinois State Medical Society is and does become apparent. As will be pointed out later, all of these achievements have been accomplished without any additional permanent staff personnel and with a possible 1965 deficit changed to a small surplus in the final audit.

House of Delegates Minutes

Minutes of the actions taken by the 1965 House of Delegates annual convention were provided in abstract form to all ISMS delegates about two weeks following the conclusion of the meeting. The June, 1965, issue of the *Illinois Medical Journal* carried this same abstract for the benefit of each ISMS member. A verbatim transcript of each House of Delegates session is always available for any member's review in the headquarter's office upon request to the Secretary-Treasurer or Executive Administrator. It is not considered practical (and too expensive) to print this bulky record of 371 pages.

Therefore, as in the past, the abstract form, which accurately details the actions of the 1965 House, will be presented for acceptance in 1966 as the official minutes of the 1965 session. This procedure permits a more rapid review of the actions of the previous House meeting and avoids additional demands on the time of the House.

The directives of the 1965 House of Delegates have been arranged into a sequence of assignments by the Board of Trustees and considerable time has been spent at each meeting reviewing the current status of each item. Complete fulfillment of each request for action has now been accomplished, and will be re-

ported in further detail by the Chairman of the Board of Trustees.

Communication with Members

A primary goal of each officer and trustee of the Illinois State Medical Society is to make a maximum of information available to the membership regarding the functions and activities of the society. New and special attempts to accomplish this have been instituted this past year. We know that not every physician will maintain the same degree of interest in all of the society's many areas of action. Therefore, a concentrated effort is made to provide a broad overall view of the society's activities within the pages of the *Illinois Medical Journal*, and to supplement this with publications and bulletins of a more specialized appeal directed to those members who have indicated an interest in specific areas (legislation, public affairs, county society leadership, etc.).

The recent practice of sending abstracts of each Board of Trustees meeting to each county society officer and delegate has been expanded for the first half of 1966 to provide for the distribution of the complete minutes. The Board of Trustees initiated this change in the hope that the finer detail provided in the complete set of minutes would be of greater benefit to county society members in their understanding of all activities. An expression of opinion by the House regarding the value of the full Board minutes and their desire to receive them, or an accurate abstract, would be greatly appreciated by the Board of Trustees.

Since 1966 will not contain a session of the Illinois legislature, the *Legislative Listening Post* in the *Illinois Medical Journal* and the newsletter *On the Legislative Scene* will not be resumed until 1967. In its place, a newsletter entitled *Government Medical Care Bulletin* will be sent to each member. This bulletin was initially developed by the Legislative Committee for the benefit of county society legislative chairmen. However, the Board of Trustees felt this information was currently so significant and important that it asked that the letter be provided to the entire ISMS membership.

A new publication debuting in January, 1966, was a monthly calendar of medical events in Illinois. Called *What Goes On*, this bulletin provides each member with a "one-stop" source of information about important medical meetings in the state. To make this calendar all inclusive, each medical group or specialty organization is asked to send notices well in advance of their meetings to the Director of Publications.

I would also like to make some special comments on the nature and volume of society correspondence with the membership. The vast quantity of mail received daily by each physician is not unknown to your officers and there have been comments by some who believe the society is distributing too much informational material. It is not the society's desire to add to the time required to review incoming mail or compete with the other matters for the physician's attention. It is our desire to get important information to every member as quickly and at as little cost as possible. Failure to keep the membership informed of current or new developments would be a far more serious criticism than the frequency of mailings. I urge each of you to recognize ISMS and AMA envelopes and to give them a moment of your time as soon as they arrive. Every mailing is screened regarding its importance in the state office, and it would not be sent unless it was considered to be worth your time in reading and the spending of your money in its preparation and mailing. Cooperation of the entire membership is needed now more than ever before, and the society's success as a unit can only be had by the participation of each member. To the extent that you participate with your society, will your thoughts guide and lead its future progress.

The Administrative Staff

Probably the one factor contributing most to the progress and increasing prominence of the Illinois State Medical Society is the permanence of its headquarters staff. From the Executive Administrator on through the division heads and many others, most have now been with the society for over five years. They have developed into a coordinated team which has served the society well. Such stability of administrative organization leads to greater efficiency and effectiveness in carrying out the projects and directives of the House. We are particularly fortunate in having the continued services of capable men of ability serving medicine in general and the ISMS in particular.

Coordination of staff activities is methodically achieved by weekly staff conferences, where the implementation of all major directives or assignments is planned, progress on projects under way reviewed and suggestions for greater efficiency evaluated. This unity of action is highly desirable for an organization with so many various activities and is to be highly commended.

Though additional assignments have been made to various divisions during the year, no additions or major shifts in organization were made in 1965. The position of Assistant Editor of the *Illinois Medical Journal* was filled on

a permanent rather than a part-time basis. For a considerable period of time, the lack of available and qualified personnel necessitated the temporary filling of this position on the part-time basis.

During the year many visits to county medical societies and other groups have been made by the Executive Administrator and staff directors. I wish to call to the attention of all county medical societies that visits by the staff (and officers) are available at any time; apparently some societies have been hesitant about requesting such services. Unquestionably, many matters of misunderstanding or lack of information could be readily solved by such visits.

Initiated by the Executive Administrator, this year has seen the completion of a committee meeting room at the headquarters office. The establishment of this room has been a great convenience to committees because of the availability of staff members and records. Meetings held here are also a saving in both staff time and society expense. All committees are urged to take full advantage of this meeting place. In addition, those who meet here get to know the society much better and quickly see and realize the magnitude of the work which is carried on at "360 North Michigan."

Finally, the staff is to be highly complimented for its services to the 63 committees of this society, most of which have at least three or four meetings per year. The work requested of the staff by some of these committees is often quite detailed and time-consuming, and without this special assistance, committee accomplishments would be greatly decreased.

Secretaries' Conference

The 1965 Conference was held in Springfield on April 4 at the St. Nicholas Hotel. F. J. L. Blasingame, M.D., executive vice-president of the American Medical Association, and Mr. Ray C. Dickerson, president of the Illinois State Chamber of Commerce, were featured speakers on the topic of physicians' responsibilities regarding medical care legislation for the aged. In addition to several subjects of interest to county secretaries in the administration of their office, a "workshop" session divided members into groups for special discussions on Legislation and Public Affairs, Public Relations, Publications and Scientific Services, State Society Business Services, and Economics and Insurance.

Leadership Conference

For 1966, the usual Secretaries' Conference format will be changed to that of a Leadership Conference. County medical society officers, by virtue of their office, should provide leadership not only to their colleagues but also among the citizens of their community as well. Therefore, county medical society presidents, presidents-elect, secretaries, executive secretaries and key committee chairmen will be invited to attend this program—the only one designed to provide a statewide forum for the leaders of county and CMS branch societies.

The program for 1966 is to be greatly expanded and speakers of national prominence have been invited to participate. In addition to many items pertinent to county medical society officers' interest, the first session will feature an outstanding presentation on leadership by Jim Low, manager, Association Department, U.S. Chamber of Commerce, Washington, D.C., and a panel on "The Latest Word in Medicare" headed by J. W. Cashman, M.D., chief of the Medical Care Division, HEW, Washington, D.C., along with national leaders of the American Medical Association and the American Hospital Association. The evening address will be "Voluntary Leadership in 1966—Are You Doin' or Duckin'" by a prominent speaker.

The second session will start with round-table "workshops" on state-county activities, where staff and board members will be available to answer questions, and followed by a presentation on state society activities correlated with "Doc's Dues Dollars' Duties Depicted." The wind-up will come at a luncheon when Milford O. Rouse, M.D., Dallas, Texas, speaker of the AMA House of Delegates, will speak on "Gearing Up for Medicine's Future."

The meeting is to be held in Springfield and is set for April 27 and 28, during the middle of the week, in the hope that this will avoid the use of week-end time which many physicians like to have for their personal activities. Attendance will provide county society officers an opportunity to receive comprehensive and current data on a variety of topics important to them personally and vital to the society's success. With the background information provided by this meeting, county delegates to the annual convention can be briefed so as to better reflect the thinking and desires of each county society.

Membership Statistics

Membership statistics and changes for 1965 are listed in the tables shown below. Rather than show only one year's information, there is listed comparative data for the last five years in order to indicate the relative changes from year to year.

MEMBERSHIP STATISTICS

	1965	1964	1963	1962	1961
Membership as of January 1	10,500	10,145	10,101	10,185	10,168
New Members	492	537	429	376	403
Reinstatements	43	211	59	72	403
Total added	535	748	488	448	589
Dropped during the year:					
Died	172	175	176	186	191
Moved from State	101	47	60	160	99
Resigned	28	7	6	9	15
Nonpayment	108	164	202	177	267
Total dropped	409	393	444	532	572
Membership as of December 31	10,626	10,500	10,145	10,101	10,185
Regular	9,429	9,412	9,097	9,056	9,156
Residents	278	230	223	254	235
Service	26	30	13	15	14
Emeritus	494	459	467	446	454
Retired	334	312	328	310	295
Hardship	45	31	17	20	20
Intern	20	26			11
Total	10,626	10,500	10,145	10,101	10,185

In no other profession does membership in a professional society matter so significantly to the general public and to the members as in medicine. With all levels of government so deeply involved in the distribution of medical services, no Illinois physician should feel that he can permit himself the luxury of not playing a personal role in medical society affairs.

Although there are many specialty societies and hospital staffs that call upon the individual physician's allegiance and time, there must be one overall organization to represent as many physicians and their interests as possible. Only the county medical society, the state medical society and the AMA are equipped to do this job. Beyond any personal gain from ISMS membership, thousands of citizens gain in thousands of ways because Illinois physicians, when called upon, can speak with one voice on the multitude of issues which are constantly arising concerning medical care.

Dues Billing Procedures

After an experimental trial for a few societies in 1965, ISMS offered each county society the service of billing and collection of the 1966 annual medical society membership dues. This centralized direct billing service was requested by over half of the county societies. An IBM service bureau is used to process the individual payments and the regular ISMS membership secretary assumes the additional responsibilities of screening and verifying each of these payments. With no increase in staff and a marked decrease in manual working hours, a valuable and extensive additional service has been made available to county societies. This service will again be offered for 1967 and any county society may have it if it desires. Notification of its availability will be sent to each society next fall.

Besides relieving the county society secretary of the burden of the annual billing and collection chore, this new procedure enables the ISMS to transmit each member's AMA dues much faster and in a more accurate manner. The information available on the IBM cards can also be used in preparing various reports that were either unavailable in the past or required extensive staff time to develop. In addition, other statistical details will gradually be added to the cards, which will permit faster and more complete service to members and various groups within the society.

1965 and 1966 Budget

The board-approved operating budget for 1966, which this year includes an operating fund allocation of $10 from the 1966 dues increase of $25, shows expenditures balanced with receipts. From the $25 dues increase, $8 has been allocated to permanent reserves, $5 to benevolence fund and $2 to contingency reserves, along with the $10 to operating funds. This is the breakdown of the dues-increase allocations requested by the 1965 House of Delegates.

Also, as requested by the 1965 House, a budget for two years (1967 as well as 1966) is being provided for the 1966 meeting. This will give delegates an opportunity to review

proposed project expenditures prior to the year under consideration, rather than after the commencement of most of the Society's annual program activities.

The society's operating fund budget expenditures were $743,800 for 1965—as opposed to the 1964 budget of $710,095. The introduction of outside funds for use in publishing the *Pulse* as a separately mailed newsletter added $15,000 of income and expense to the budget in 1965 that did not occur in 1964. This is cited only as one example of how unexpected sources of outside funds can add to the overall budgeted income and expense, without changing the net surplus or deficit picture. Events similar to this may take place in the future. The 1964 actual deficit of $31,338 was reduced to a budgeted surplus of $1,200 in 1965, partially through reassignment of staff time to the administration of the Eldercare public information campaign. This precluded the expenditures of some regular operating funds because of a shortage of staff time to complete all original 1965 programs.

As the 1966 budget is reviewed, several changes in committee and project allocations will be noted. These variations were made by the Finance Committee after several long meetings devoted to planning and balancing the budget, during which consultations were held with all staff directors and many committee chairmen. It is to be noted that neither the 1966 nor the 1967 budgets include any new projects for these years, and should the House of Delegates direct any new programs of a major nature, an accompanying method of financing them will be necessary for their implementation.

Investment of Reserves

Income from all investments amounted to $15,468 in 1965, compared with $15,373 in 1964 and $17,160 in 1963. Investment return is subject to variation each year because of changes in the national money market and the timing of the society's cash requirements. We constantly seek to maximize the return from our reserves and short-term cash surpluses consistent with the prime objective of minimization of risk of loss. A yearly comparative analysis of investment income is shown below.

All investments are made upon recommendation by the bank, after review by the Finance Committee and approval of the Board of Trustees. Custody of all securities is maintained by the bank, and monthly reports of principle and income are made to the Society. No material purchases or sales (other than stock splits, stock dividends, sale of rights and warrants, etc.) occurred in 1965. The Board of Trustees has placed the society's reserve funds in the hands of professionals for investment in a managed fund of "Blue-chip" common stocks and government bonds. This was done not to place the society into the investment business, but in order to protect the reserve funds from future loss in purchasing power caused by the chronic (and possible future acute) inflation experience of this country since the beginning of World War II.

Financial Statements for 1965

Condensed financial statements are presented here for the benefit of the entire membership. The complete audit report for the year ending December 31, 1965, is to be given to each member of the House of Delegates and are available for review by any member at headquarters office. Copies of the 1966 and 1967 operating budget, as approved by the board, will be presented to the Reference Committee for its consideration and comment. Dr. Carl E. Clark, chairman of the Finance Committee; Mr. Robert L. Richards, the Executive Administrator; Mr. Roland I. King, Director of Business Services, and myself will be available at the reference committee hearings to assist in any way possible.

	1965	*1964*	*1963*	*1962*	*1961*
Interest on U. S. Government Securities	$ 6,481	$ 4,110	$ 1,679	$ 2,667	$ 3,081
Interest on bank savings accounts	6,762	9,365	14,037	11,735	10,016
Dividends	2,225	1,898	1,444	428	0
TOTAL	$15,468	$15,373	$17,160	$14,830	$13,097

At the end of 1965, the following listing shows the reserve funds invested under the supervision of the Continental Illinois National Bank Trust Department:

	GENERAL FUND		*BENEVOLENCE FUND*	
U. S. Government Bonds	$ 35,770	24.6%	$ 78,947	50.3%
Investment-grade common stock	55,435	38.2%	58,835	37.5%
Bank savings accounts	54,056	37.2%	19,177	12.2%
Total	$145,261	100.0%	$156,959	100.0%

ILLINOIS STATE MEDICAL SOCIETY

POSITION STATEMENT—DEC. 31, 1965

	Total	General Fund	Benevolence Fund	Property Fund	Student Loan Fund	Suppl. Empl. Retirement Fund
ASSETS						
Cash	$133,049	$ 75,927	$ 19,677	$ 9,463	$ 2,982	$25,000
Receivables	19,805	19,805				
Investments, at cost	261,631	92,116	140,015		29,500	
Student loans	68,750				68,750	
Prepayments and advances	6,763	6,763				
Office furniture and fixtures	68,831			68,831		
Interfund Receivables (payables)	0	(2,626)	3,103	(477)		
Total Assets	$558,829	$191,985	$162,795	$77,817	$101,232	$25,000
LIABILITIES AND FUND BALANCES						
Payables	$ 13,573	$ 13,573				
Accrued expenses	9,342	9,342				
Deferred income	6,325	6,325				
Fund Balances	529,589	162,745	162,795	77,817	101,232	25,000
Total Liabilities and Fund Balances	$558,829	$191,985	$162,795	$77,817	$101,232	$25,000

INCOME STATEMENT—GENERAL FUND—YEAR ENDED DEC. 31, 1965

INCOME		*EXPENSES*	
Membership dues—		Board and Officers	$ 35,965
Basic dues—$80 per member	$758,296	ISMS and AMA Meetings	48,635
Less Allocations:		Administration	70,350
AMA-ERF—$20 per member	189,465	Business Services	82,989
Benevolence Fund—$2 per member	18,946	Springfield Office	45,298
Total Allocations	208,411	Public Relations	89,873
Net basic membership dues	549,885	Legislation and Public Affairs	111,094
Supplementary dues—$25 per member	230,750	Economics and Insurance	26,695
Voluntary dues—$5 per member	27,025	Publications and Scientific Services	58,764
Total membership dues	807,660	Illinois Medical Journal	101,031
Illinois Medical Journal	76,016	Non-Departmental	86,436
"PULSE" newsletter	14,666	Eldercare Information Campaign	196,289
Annual Convention exhibits	16,158	TOTAL EXPENSES	$953,419
Interest & dividends	15,468	EXCESS OF INCOME OVER EXPENSES	$ 9,640
All other	33,091		
TOTAL INCOME	$963,509		

EXECUTIVE ADMINISTRATOR
AF-2

This year will complete my sixth year as Executive Administrator of the Illinois State Medical Society. In each of my reports to the House of Delegates I have attempted to provide a report which covers the essential activities of our staff, as well as my personal activities throughout the year.

As is customary, a written report of my activities as well as staff services is prepared for each meeting of the Board of Trustees. Important changes in personnel are always noted, and key functions are discussed in detail. No major activity of any staff member, or myself, is carried out without the approval of the board and its appropriate committees. Minutes of weekly staff conferences are distributed to the board so that they may at all times be aware of the administrative details necessary in the operation of the society.

In a recent television broadcast regarding America and its people, Robert Preston stated that: "Challenge is the mainspring and core of all human activity—if there is disease to be cured, we find a cure; if there is a mountain to be climbed, we climb it." This quotation reminds me in many ways of the challenges which medicine has faced during the past year. Because of those challenges the administrative staff has had to reflect in its work the kind of planning and organizing which is required to assist the Illinois State Medical Society's committees and the board in meeting their challenges. Some of the important challenges which we have faced during 1965-1966 are therefore reported here,

because I feel they are significant and represent the type of contribution which has been made by our employees.

I. Budget, Planning, and Programming

Since the 1965 session of the House of Delegates which allocated, or earmarked new dues money to certain funds of the society, with an additional allocation of approximately $12 per member for the General Fund, much staff time went into the preparation with committees and their chairmen on the recommended budgets for 1966-67. On the surface it may have appeared that new money for continuing programs, or recommended programs, would be available because of the dues increase. This is not necessarily so because the new money included in the 1966 dues increase was approximately the same amount of money that had previously been donated in 1965 voluntarily by individual members through contributions to the Public Affairs and Political Action program ($75,000), and the Medical Benevolence program ($26,000). In 1965 these, therefore, totalled $101,000, the equivalent to more than $10 dues increase per member.

The increase in cost of living alone during 1965 was 2.2 as reported by the latest governmental figures. If this percentage were applied against our entire budget for the purchase of printing, paper, employees' salaries, etc., the total increase would be approximately $15,000, or the equivalent of $1.50 in dues increase per member. These combined total almost as much in 1965 as the aforementioned $12 dues increase for the General Fund authorized for 1966.

The Chairman of the Finance Committee and the Board of Trustees will certainly report in more detail about the budget. But suffice it to say that many hours of time, effort and study, as well as final preparation were involved in the budgets recommended to the House of Delegates by the Board of Trustees for the years 1966-67. This then, regardless of what it may have appeared to be on the surface, was a challenge which we believe staff has met during this past year.

II. Voluntary Health Agencies

In August of 1965, the Board of Trustees approved the establishment of an Illinois Council of Voluntary Health Agencies, and the initiation of this council by an appropriate committee of the state medical society. Formerly, liaison with voluntary health agencies had been minimal and without any common meeting ground for furthering their objectives, or coordination with the attitude and thinking of the medical profession, except as physicians served on the voluntary health agency boards of directors. It was indeed a challenge that was given to our Committee on Public Relations, and its Subcommittee on Voluntary Health Agencies to establish such a council, and achieve a good working relationship.

In a recent meeting held on February 16, 1966, it was my pleasure to see the final consummation and establishment of the Illinois Council of Voluntary Health Agencies. This has been achieved through a series of long and difficult meetings with those representatives who undoubtedly had many questions to ask, many reservations in their minds, and certainly some questions regarding the accomplishments of such an organization in the future. It may be trite to observe that our committees and staff did in a short span of one year what many state medical societies have been struggling to do for many years. This is not to say that we achieved everything we wanted to achieve, but it is to be observed that given approval by the Board of Trustees or the House of Delegates, committees working in concert with well qualified staff individuals can carry out the wishes of medicine. This then was another challenge which we accomplished and completed in 1965.

III. Public Affairs

High on the priority list of programming during the past year was an objective to solidify and interpret to the officers of county medical societies the real need for understanding of the public affairs programs. Early last fall a series of Circuit Rider meetings was arranged in order to attract the leadership of county societies and their public affairs committee chairmen to attend an orientation type of meeting aimed at presenting not only the need for public affairs activities but also the political consequences of apathy and inactivity. The Committee on Public Affairs combined with staff to complete and receive good attendance at eleven meetings. We believe that this challenge is a continuing one, and must be doubled in effort during the next six months. However, I take this opportunity to point out that we are at least on our way to meeting this challenge, and now that budget has been made available to this committee, it would seem that it has some permanency, and is on its way to accomplish it goals.

IV. Medicare

On October 2-3, 1965, the AMA at a special meeting of its House of Delegates and its actions regarding Medicare presented a new challenge: To achieve understanding by the profession of what Public Law 89-97 con-

tained, as well as to make recommendations and suggestions regarding the attitude which physicians might adopt concerning the implementation of the various features of that law. On direction by the Board of Trustees we initiated a series of Medicare implementation meetings. Meetings have been held in a number of county and branch societies. There have also been district meetings and area meetings. We believe that the majority of the profession has been advised, and information has been made available to them on which they may now pass judgment. Communications via government medical bulletins, articles in the *Journal*, and other media have been used to meet this challenge. Continuing during the next few months up until July 1 will be additional efforts by staff members, the board, and appropriate committee members to maintain up-to-date information and its dissemination to the members of the profession.

This again is a continuing challenge, but we believe that we have met every request and reasonable accomplishment in this area.

V. Staff Planning Conferences

Early in August, 1965, I recommended to the Board of Trustees that a series of staff planning conferences be authorized to be held with properly qualified consultants in order to ascertain the strengths and weaknesses of our present programming, and to initiate challenges to our staff, as well as to document for the Board of Trustees those things which in the opinion of the staff needed to be emphasized in the future. The hope that some priorities might be better determined as a result of those conferences was indeed our wish. It is not possible in the preparation of this report to indicate the detailed results of those planning conferences. However, it is my intention, as has been my pleasure in the past, to present the findings of the staff planning conference in oral form to the House of Delegates. A copy of those remarks will be made available to the reference committee for its consideration. Along with these remarks will be the comments and opinions presented by the Executive Committee.

VI. Membership Opinion Survey

One of the first recommendations made as a result of the previously mentioned staff planning conferences was the institution of a survey of ISMS membership. Briefly, the purpose of this study is to provide the leadership of the Illinois State Medical Society with an objective membership appraisal of the society—its aims, leadership, activities, future direction, shortcomings. The results of this study will be presented to the House of Delegates by a representative of Opinion Research Corporation. It is my feeling that the Board of Trustees acting on staff recommendation was most alert and wise, not only from the standpoint of general membership reaction, but also from the standpoint of reconfirming the general direction in which the society's program should be pursued. I am confident that the results of this survey will lead us to thinking further on the major problems confronting the profession in the future, and will help in determining the activities which should be given priority during the next five to ten years.

VII. Personnel Changes in Staff

During the year there have been a few resignations and changes made in our staff. It is my personal opinion, also based upon our salary structure and organization that in each instance the replacement has been equal if not better than the person who has left the organization.

This is a continuing challenge for improvement to meet the demands of organization, but at the same time to stay within the budget to employ adequately and well qualified staff.

VIII. IBM Processing

In recent years automatic data processing equipment has proved to be most useful to many business firms and large associations. Upon investigation we found that it would be possible to establish and maintain up-to-date IBM records on all of our membership. This included billing procedures for dues, AMA-ERF donation records, and accessible age classifications, specialty information, and other helpful data in our day to day activities. Late in 1965, permission was given by our Board of Trustees to proceed on the implementation of such an IBM system. The immediate challenge was to complete the records in time for use in direct billing to approximately fifty county medical societies which agreed to this suggestion. It was no small task which was accomplished, and it is now in operation. We recognize that no first time for a system of this nature can ever be perfect. However, we have already begun to realize that through the use of reports and other information that this will be of most valuable assistance to our staff and committee programs. Here then is another challenge which has been met and accomplished to a great degree during 1965-66.

IX. Appreciation and Conclusion

During the year 1965-66 there were other challenges. I have mentioned the above as illustrations only. To prepare an exhaustive

list would make this report much too lengthy. To mention only a few additional items, I would like to cite the preparation for the first Narcotics Conference, the Annual Press Awards Dinner, meetings with hospital based specialty groups regarding their problems in the implementation of Medicare, the continuing study of the medical schools, and the medical education problems, etc.

The continuing responsibilities of staff to follow up on AMA actions, to implement requested actions by our own House of Delegates, and the myriad tasks concerning the Board of Trustees and committee requests required continued maintenance of our present staff. There have been no additions to our staff during the past year. There has been one full-time person replaced by a part-time individual.

My personal activities continue to include, as approved by the Board of Trustees, services as Executive Director of the Illinois Association of Profession and the chairmanship of the Association Committee of the Chamber of Commerce of the United States, in addition to my other responsibilities.

Of course nothing of the above nature could be accomplished without the fine support and co-operation of the Board of Trustees, the committee chairmen, and finally the excellent staff. We hope we may continue to serve you in like quality and quantity during the succeeding years.

Robert L. Richards, *Executive Administrator*

ARCHIVES COMMITTEE
AF-3

The Archives Committee reports that the State of Illinois is proceeding with the establishment of the Abraham Lincoln Shrine Museum in the Old State Capitol Building in Springfield. The major project is the restoration of the building to its original 1837 design. Dismantling of the Old Capitol is presently being accomplished. The architect's plan is to raze the building block by block, numbering the blocks as they are removed from the structure, erect a reinforced steel shell, and restore the blocks to their original positions to create the 1837 design of the building. It is anticipated that the restoration work will be completed by 1968.

The Archives Committee has proceeded with plans, as authorized, to create within the Abraham Lincoln Museum a special ISMS historical museum centered on Lincoln and his doctors. These plans entailed: (1) engagement of a museum specialist to create plans to present a museum exhibit representative of doctors and illnesses in the life of Lincoln (this phase completed); (2) solicitation of outside sources by the ISMS Educational and Scientific Foundation for funds to finance the ISMS museum project. The ISMS Educational and Scientific Foundation's solicitation of 40 selected Illinois foundations in April 1965, personal contacts suggested by Dr. Morris Fishbein in July, and solicitation of 30 national drug houses in November 1965 were unproductive. Consequently, funds are presently unavailable from outside sources to assist in the financing of the ISMS museum project.

In view of the foregoing, the committee wishes to inform the House of Delegates that the Archives Committee is willing to guide, supervise, arrange, and establish the medical museum but that matters of financing and implementing must be done by the society and the Finance Committee of the state medical society be assigned the responsibility of embarking on a program to raise the required money to participate in the Lincoln Shrine Museum.

The Archives Committee recommends that the Illinois State Medical Society commit itself to raising the funds required to finance the establishment of the ISMS medical historical museum. To implement financing, the committee suggests the following alternatives as possible methods of financing: (1) extension of special dues allocation for ISMS members (one dollar per year) for 15 years; (2) engage professional fund-raising organization; (3) special per-member museum assessment of $20; (4) disbursements from yearly income; (5) disbursements from present reserve.

The Archives Committee believes that the ISMS museum project is one of great value which should be vigorously pursued by the society. The committee further believes that the benefits accruing to the society in perpetuity are so significant as to dwarf the present financial commitment.

Emmet F. Pearson, *Chairman*
Carl W. Hagler Clifford E. Smith
Leo Zimmerman

MEDICAL STUDENT LOAN FUND COMMITTEE
AF-4

Recommended Changes in Program Administration: Experiences of the past year have pointed up the need for consideration of changes in our program as it is presently administered. In the 17 year life of this program, many changes have occurred in medical practice trends and within medical education itself.

Community health needs reflect these changes. In the past, these needs were satisfied with the utilization of uncomplex techniques and procedures. The general practitioner alone could meet the challenge of medical care in the rural area. As medical science advanced, the community's needs also progressed to the more demanding level of the present. The general practitioner now needs the help of specialist colleagues in his community and hospital. (One problem resulting from these changes has been an increasing tendency for the participants within the program to resist the old restrictions regarding specialization and practice site location. This means that an increasing amount of the committee's time is being spent assuring that participants fulfill all of their contract obligations.)

It is the opinion of this committee that these problems and trends dictate the outlines for changes in our rural health/medical student loan fund program, so that it may keep pace with and be reflective of a current approach to medical service needs and medical practice trends.

The committee feels that instead of concentrating on enforcement of obligations based on needs of previous years, we should direct our effort toward making our program less restrictive and more in keeping with the needs of the rural community. We feel that each participant should be enabled to fulfill his personal professional goals, whether they be general practice or specialty. We hope, of course, that general practice will continue to be the goal of many.

For these reasons, the committee recommends the following changes in the program for consideration by the House of Delegates:

1) The restriction on specialization should be removed and each participant should be allowed to complete his medical education, including his immediate postgraduate training, on an unrestricted basis. His *practice location* will still be subject to the committee's approval.
2) The practice site should be limited to a rural area, as verified by the Medical Student Loan Fund Board. The participants' specialty training would be a factor in the board's decision.
3) The committee be authorized to grant loans to a total of $6,250, which would carry thru the student's internship, rather than the end of his fourth year of medical school.

The three points listed above have already been approved by the joint committee members from the Illinois Agriculture Association Board of Directors. These men feel them to be necessary to the continued success of this program in providing necessary medical care services to the rural people of Illinois. University of Illinois medical school officials feel these changes would help our program to attract a better qualified applicant in the future, something they feel is essential to the continued existence of the program.

It is the committee's thinking that the key requirements of five years of practice in an approved location and a $5,000 penalty for failure to comply should be retained. It is felt that with a liberalization of goals, the desire of the participants to violate their agreement by not locating in an approved community in Illinois for a minimum of five years will be negligible. Certainly, those that do violate the more liberal terms will have no valid excuse to offer as justification for their actions.

We feel that the original intent of this committee was to assist in the provision of *medical care* to the rural areas in the state. The objectives of the committee have never changed, but it may be possible in making these changes to strengthen the program and continue to serve the diverse health needs of the community.

Annual Interview Meeting: On December 29, 1965, the Joint Loan Fund Board interviewed and studied the qualifications of 30 applicants for recommendation to medical school in the fall class of 1966. There are 10 positions set aside in each freshman class at the University of Illinois College of Medicine, to be filled by students recommended by the committee. Those recommended may take advantage of low interest loans of $1,259 yearly (present maximum $5,000 after four years). Funds for these loans were provided on a 50/50 basis by I.S.M.S. and the I.A.A. in 1948 through 1960 . . . $84,500 apiece.

Loan Fund Financial Status: The total value of the Student Loan Fund at December 7, 1965 was $203,488. The assets of the fund at that date were:

$ 54,000 U.S. Treasury bills
$142,575 2% Student promissory notes
$ 6,913 Cash

The fund received 2% interest income in 1965 amounting to $2,862, including penalties of additional interest upon default of the contract terms. $1,362 was received from investment in U.S. Treasury bills. The only expense of the fund in 1965 was $1,625 for bank trust department administration fees. A trust fund surplus of $2,599 resulted for the year.

Jack L. Gibbs, *Chairman*
Thomas C. Bunting Jacob E. Reisch

BENEVOLENCE COMMITTEE
AF-5

In 1965 the Benevolence Committee distributed 468 monthly payments in varying amounts to 43 qualified recipients. These payments totaled $48,250 for the year and ranged from $50 to $200 per person per month. (Breakdown: $50—2 recipients; $60—1; $65—1; $75—5; $85—2; $90—1; $95—1; $100—13; $125—5; $140—1; $150—5; $200—3.) The total expenditures of $48,250 were dispersed from 1965 Benevolence Fund income of $59,212.15. The fund experienced a $10,962.15 excess of income over expenditures in 1965.

For January 1966, the committee has 40 recipients receiving $4,370 in total each month. This payment level will require $52,440 in funds for the year 1966. Additional money will be expended as new recipients are added to the rolls of the benevolence program. A total of $55,000 is projected for 1966 benevolence payments: income estimated at $79,600; excess of income over expenditures, at $24,600.

Keith H. Frankhauser, *Chairman*
Raleigh C. Oldfield John H. Steinkamp

AMA DELEGATION, 1966
AF-6

The importance of a well informed and smooth functioning delegation has been stressed for the past several years. During 1965 several innovations have been developed to contribute to this ultimate aim for the Illinois group.

(1) All delegates and alternate delegates are now invited to attend all regular meetings of the Board of Trustees during the year. There are seven delegates and seven alternates who are not board members, and the need to keep the entire delegation informed is obvious.

(2) Since the members of the delegation will be in attendance at the four board meetings, held on Saturday evenings and on Sunday mornings, the delegation will meet for breakfast on Sunday to discuss business pertaining to the AMA House of Delegates.

The delegation has been working under a firm budget, and has kept well within the amounts allocated. The delegates and alternates are given first class air travel, plus $30 per diem to cover all other expenses, including hotel, meals, etc. The special called meeting of the AMA House in Chicago October 1 and 2 caused an additional expense of $1,774.92, but the expenses of delegates only were assumed for this meeting. The alternates were invited at their own expense.

The delegation has gone on record to develop certain policies regarding the expenses of the headquarters suite, the Illinois luncheon, etc. We call your attention to the fact that the actual expenses for the AMA meeting for the year 1965 were materially below the estimate. The June 1966 meeting will be in Chicago and the travel expense for the delegation will be much less than usual.

Expenses are to be outlined, and estimates and costs secured for the chairman and the secretary of the delegation to check so that the budget responsibility is clearly established. Although certain activities are approved by the delegation vote, the actual carrying out of these suggestions depends upon the budget and the total cost involved.

Dr. Percy E. Hopkins, chairman of the Board of Trustees of the AMA, completes his years of service in June of 1966 and is not a candidate for re-election. He will be presented with a plaque by the Illinois delegation before the AMA House, and the luncheon on Monday noon will be given in his honor.

We will have two candidates for elective positions to present to the AMA House in June of this year. Dr. Walter C. Bornemeier is a candidate for the office of Speaker of the House, and Dr. Burtis E. Montgomery for a position on the Board of Trustees to replace Dr. Hopkins. All efforts will be made to bring both campaigns to successful conclusions. At the present time, both Dr. Bornemeier and Dr. Montgomery are unopposed.

The members of the delegation believe that the outstanding work Dr. Montgomery did in Chicago at the special session of the House in October as chairman of the reference committee to consider the Medicare problem will stand him in good stead, and the opportunities given Dr. Bornemeier as vice speaker have proven to the membership that he will provide a capable and able speaker to follow Dr. Milford Rouse, who is a candidate for president elect next June.

The last time a count was made, Illinois had some 55 to 60 physicians serving on various committees, editorial boards for specialty journals, or in an advisory capacity at the AMA. Since we are the fourth largest medical society in the country, and the headquarters office of the AMA is located here in Chicago, it is most important that we cooperate and continue to try in every way to make our influence felt at the national level.

Since all policy rulings of the AMA are made by the House of Delegates and carried out by the Board of Trustees and the more than 900 employees in Chicago and Washington, D.C., it is obvious that the physicians elected to serve the Illinois State Medical Society must be able and willing to devote time and effort to representing the 10,000

members of this society. The actions taken by the AMA House represent the majority vote of American medicine sitting as the duly elected representatives of their constituent state societies. By the thinking expressed at the state society level, these representatives are guided and influenced in their actions.

1965 was a very unusual year and saw two special meetings of the AMA House. February 6-7 the House met in special convention in Chicago and was reported in our 1965 report. June 20-24 the House met in New York for the annual meeting with the following appointments on reference committees:

E. W. Cannady—Amendments to Constitution and Bylaws

William K Ford—Board of Trustees

H. Close Hesseltine—Legislation and Public Relations

B. E. Montgomery, Chairman—Tellers

Paul H. Holinger—Teller (delegate from Section on OLR)

October 2-3 the House met in special convention in Chicago and Burtis E. Montgomery served as chairman—Legislation and Public Relations.

November 28-December 1 the House met in Philadelphia during the clinical session and the following served on reference committees:

Frank H. Fowler—Insurance and Medical Service

Leo P. A. Sweeney, Chairman—Medical Military Affairs

Maurice M. Hoeltgen—Public Health and Occupational Health

Paul H. Holinger—Amendments to Constitution & Bylaws (Delegate—Section on OLR)

For the information of members of our own House of Delegates, special commendation should be given the section delegates and alternates from Illinois who meet with our group, work with us at all meetings, and whose service and experience contribute materially to our efficiency and influence.

It is most unusual that the House should meet four times during any one year, and in all probability this will not occur again for some time. Illinois is most fortunate since these called meetings were held in Chicago, resulting in a minimum cost for the delegation.

At the New York meeting, Illinois introduced two resolutions. Resolution No. 25 dealt with the payment for blood and blood plasma under society sponsored insurance policies and was adopted. The resolve stated: "The AMA House of Delegates stands opposed to the payment for whole blood and red blood cells by prepaid health programs. This is not to be construed to include opposition to the payment for the costs of cross matching, typing, administration of blood or by-products of blood . . ." and that "exceptions may need to be made in cases where an unusually large number of transfusions are required and where volunteer blood donors are not available . . ."

Resolution No. 48 was introduced jointly with Tennessee and a similar resolution was presented by Pennsylvania . . . "Resolved that the House of Delegates hereby commends those state medical societies which have approved voluntary automatic billing procedures for AMPAC and/or state societies of a similar nature." The resolution was combined with others of a similar nature, rewritten by the Reference Committee and the substitute resolution, reaffirming the previous position of the House, was adopted by official action.

At the Philadelphia meeting, Illinois also introduced two resolutions. One (No. 3) dealt with the effect upon population restlessness of overcrowded and unsanitary living conditions. The resolution was not adopted but a substitute resolution was approved which stated: "Resolved that the AMA encourage the medical profession at state and county levels to work in closer liaison with their respective health officers to improve general health conditions of our population."

The second (Resolution No. 29) dealt with the individual physician's right to choose the method of compensation under PL 89-97, and was considered with several other resolutions of similar nature. The substitute resolution was approved by House action and upheld the intent expressed in the Illinois resolution.

At the last session of the House in Philadelphia the Speaker, Dr. Milford O. Rouse, asked Dr. George F. Lull to stand and receive the recognition and acclaim of the House, as he was attending his last official meeting as an elected member of the Illinois delegation.

For the past years Dr. Lull has enjoyed various positions in the AMA—first as delegate and/or alternate from the United States Army Medical Corps, then as Secretary and General Manager of the American Medical Association for over 15 years, and recently as alternate delegate from the Illinois State Medical Society.

As President of the ISMS, Dr. Burtis E. Montgomery presented the ISMS check in the amount of $189,000 to Dr. Raymond M. McKeown, president of the AMA-ERF. Illinois presented its largest check in honor of the first woman member of the AMA, first woman delegate to represent a state medical society in the AMA House, and first woman to serve on the staff of Cook County Hospital—Dr. Sarah Hackett Stevenson of Chicago. Dr. Stevenson had represented the Illinois State Medical Society in Philadelphia just 90 years before—at the 1876 meeting.

The work of the Illinois delegation for the 1966 meeting to be held in Chicago was begun

last year. Dr. Noel G. Shaw of Chicago was named the General Chairman of the Local Committee on Arrangements, and Dr. Burtis E. Montgomery of Harrisburg was selected his co-chairman. Members of the Board of Trustees of both the Chicago Medical Society and the Illinois State Medical Society have assisted in making plans for June. Since Illinois undoubtedly will be the host society about every fourth year, it behooves us to set up procedures in this area as well. The AMA has assumed the cost of many of the social items which in the past were charged to the host society and asks only cooperation and assistance in entertainment of delegates and their wives. Plans are being developed to have an Illinois physician and his wife at each table to act as hosts at the House of Delegates' dinner scheduled for Monday evening, June 27 at the Palmer House.

Information any member of the House of Delegates desires relative to national planning, AMA delegation procedures, costs, and anticipated activity will be furnished.

Edward W. Cannady, *Chairman*
Maurice M. Hoeltgen, *Secretary*

Walter C. Bornemeier	Arthur F. Goodyear
Harlan English	H. Close Hesseltine
William K. Ford	Burtis E. Montgomery
Frank H. Fowler	H. Kenneth Scatliff

Leo P. A. Sweeney

THE EDUCATIONAL & SCIENTIFIC FOUNDATION AF-7

A brochure describing the Educational & Scientific Foundation and listing its members has been completed and will be distributed to potential donors, including all members of the Illinois State Medical Society, in the near future. The booklet is expected to fill a long-felt need for explanatory material to be handed or sent to individuals and organizations to whom the Foundation is making a plea for funds.

For example, if the brochure had been available during the past year, it would have been included with the many letters that the Foundation sent out on behalf of the Archives Committee in search of funds for the proposed medical museum in the Old State Capitol in Springfield. Although the lack of a suitable brochure had no bearing on the Foundation's failure to secure funds for the museum, its enclosure with the museum letter might have elicited some interest in one of the other Foundation projects awaiting financial backing.

On the positive side, the Foundation is in receipt of $5,000 from Merck Sharp & Dohme for renewal of its support of the Scientific Speakers Bureau, and it will administer funds from Lederle Laboratories for publication of *What Goes On in Illinois*, a calendar of medical meetings distributed by the Illinois State Medical Society 10 times a year.

Quite recently the Foundation entered into a contract with the Water Conditioning Research Council of Wheaton, and has begun a study of "The Role of Sodium Chloride in Human Physiology." The study is being financed by the Water Council and carried out under the direction of Dr. James R. Wilson.

As a fund-raising project in the immediate future, the Foundation expects to offer specially-designed plaques to Foundation contributors. These plaques are now being designed and announcement of their availability is expected soon.

E. A. Piszczek, *Chairman*

W. E. Adams	Caesar Portes
B. E. Montgomery	Jacob E. Reisch

CONSTITUTION AND BYLAWS

COMMITTEE ON CONSTITUTION & BYLAWS CB-1

Four recommendations made by reference committees of the 1965 House of Delegates were referred to this Committee on Constitution and Bylaws by the House and were considered first.

A) The Report of the Reference Committee on Administrative Services recommended that the bylaws establish a standing Committee on Administrative Services to be elected by the House, to meet quarterly, to report to the House, and to review currently the administrative activities of the society.

The Constitution and Bylaws Committee believes that the creation of such a standing committee is impractical and unnecessary because

(1) All transactions of each meeting of the Board of Trustees are abstracted and reported to the membership in the *Illinois Medical Journal* and complete and unabridged minutes of each meeting are mailed to all county medical society officers, all members of the House of Delegates, as well as all officers and trustees.

(2) Each officer and trustee submits a report to the House of Delegates.

(3) The Reference Committee on Administrative Activities reviews the reports of the

officers and the Executive Administrator and hears all interested members who wish to discuss the activities of the Division of Administrative Activities.

We recommend that the suggestion of the Reference Committee be rejected.

(B) The same reference committee recommended that the membership of the Reference Committee on Administrative Activities be enlarged to six members, and that at least two of these members shall have served on the committee the previous year.

The Committee on Constitution and Bylaws agrees with the intent of this recommendation but sees possible difficulties in implementing the recommendation. Therefore we recommend that instead of incorporating the recommendation in the Bylaws, that the House of Delegates be asked to approve a policy statement such as:

"The House of Delegates of the Illinois Medical Society directs that the Speaker of the House shall appoint to the Reference Committee on Administrative Activities, whenever practical, at least two members who have served the Committee during the previous annual meeting."

We believe that an odd number of members is desirable on any committee, and recommend no change in the number on this reference committee.

(C) The Reference Committee on Miscellaneous Business recommended that the Policy Committee of the Board of Trustees sit as a reference committee of the House to consider changes proposed by delegates or members, to revise the Policy Manual, and to present the Policy Manual to the House.

The Bylaws state that the Policy Committee, a committee of the Board of Trustees, "shall continually review past and current proceedings of the House of Delegates to determine the established policy of the ISMS," and the Constitution states: "The House of Delegates shall set the basic policy and philosophy of the Society."

This committee believes that policy recommendations are initiated by

(1) resolutions from component societies and individual delegates; and

(2) by recommendations included in all reports to the House of Delegates from committees (standing, committees of the board, ad hoc, and from officers, trustees, etc.)

that these proposals are reviewed and discussed in reference committees, then reported with recommendations to the House of Delegates, and that then, BY ITS VOTE, the House of Delegates establishes policy. We believe that changes in policy should not be subject to review by the Policy Committee, and that the reference of recommended changes in policy to the reference committee would frequently delay their establishment. We also feel that since the Policy Committee is a creature of the Board of Trustees, the board might then be accused of usurping the prerogative of the House.

We do NOT recommend that adoption of this recommendation of the Reference Committee on Miscellaneous Business.

(D) The Reference Committee on Publications and Scientific Services was not aware of the changes proposed by this committee, and adopted by the 1965 House of Delegates modifying the method of appointing the officers for the scientific sections at the annual convention. We believe that the action taken by the House adequately corrects the situation which prompted the reference committee recommendation, and that no further action is necessary.

The second recommendation of this reference committee—that the same officers be required to submit programs for the sections seven months before the annual convention, is unrealistic. We believe that programs should be developed long before that deadline, and that any desired deadline should be established and enforced by the chairman of the Committee on Scientific Assembly. We therefore recommend no action be taken on this recommendation.

From various sources five other suggestions for modifications of the Bylaws have been received:

(E) Ex-officio membership in the House of Delegates, without the right to vote but with the privilege of the floor, for past speakers, was proposed.

The committee believes that this courtesy should be extended to the past speakers as it is to past trustees, and we will recommend that

CHAPTER III, Section 1, last sentence be AMENDED TO READ:

"Past trustees *and past speakers* shall be members of the House of Delegates without the right to vote."

(F) A request from one source was received that the Speaker of the House be given full membership with the right to vote in the Board of Trustees, and from another, that the vice presidents be accorded similar privileges.

This committee agrees that, since the Speaker of the House is the principal officer of the House, that he has the obligation of organizing the program of the business portion of the annual meeting of the House of Delegates, and frequently has the obligation of discussing and moving business before the board, that he should have the right to move, and to vote

on matters before the board. We therefore will propose that

CHAPTER VI, Section 1, Paragraph 1, line 9 be

AMENDED TO READ:

. . . "The president, the president elect, *the speaker*, and secretary-treasurer. . . ." and that the same chapter and section, second paragraph be

AMENDED by

DELETING FROM LINE 1, the words: "*the speaker*" so that it will read:

"the vice presidents and the vice speaker" . . .

The committee believes that the vice presidents and vice speaker are subsidiary officers who are, by custom, usage and intent, provided to act in the stead of the principal officers, not coincidentally with them. We even see the possibility of a vice officer acting in a manner contrary to the intent of the principal officer, a situation certainly not intended at the time of their creation. Therefore we suggest that these officers be continued as members of the Board, without the vote.

(G) A request was received that this committee outline the duties of the two vice presidents.

A review of the bylaws does not find that any specific duties are assigned to either of these officers. However, the usual authorization for Robert's "Rules of Order, Revised," to guide in all procedures not specifically covered, is present.

Robert's states that the vice president acts for the president in the absence or inability of that officer to perform the duties of his office. He shall act for the president when asked or delegated by that officer to do so, and he shall perform such duties as the president shall request.

Succession to the office of president is provided by the bylaws to the first vice president, but not to the second.

The committee believes that it should be the prerogative of the president to perform those duties of his office that he feels he can physically and conveniently, and that he may delegate to either vice president those duties he feels they, by rank or ability, are particularly capable of implementing. Therefore we propose that

CHAPTER V be

AMENDED by striking the present Section 2, and

ADDING A new Section 2, which shall read:

Section 2. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting implement and advance the programs and policies of the president.

"In the event of the president's death, resignation, or removal from office, the 1st vice president shall succeed to the presidency.

"In the event of a vacancy in the office of 1st vice president, the president shall fill the office by appointment."

(H) The Speaker of the House with a silent but audible endorsement by the administration, proposed that the bylaws require all county societies to elect their delegates to the House of Delegates prior to December 31, and that the societies be requested to report the names of the delegates to the headquarters office by January 15 . . .

Such procedure would, among other things facilitate the appointment of the reference committees for the House of Delegates, annual meeting committees, and would insure the appointment of the best men available.

CHAPTER III, Section 5, third paragraph, line 2 be

AMENDED to read:

"The term of office of a delegate shall begin January 1st *following his election*, and shall. . . ." and that this would then read:

"The term of office of a delegate shall begin January 1, *following his election* and shall be for two years, or until his successor has been elected . . . Component societies with one delegate only, may elect for one year."

Also we propose that

CHAPTER XI, Section 9, be

AMENDED by striking the last six words "the first of February each year" and

SUBSTITUTING therefor

"The fifteenth of January each year" so that CHAPTER XI, Section 9, would then read:

"The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before the *fifteenth of January each year.*"

(I) A proposal that the deadline for the payment of dues be advanced from April 1st to March 1st was considered.

This committee proposes that

CHAPTER XI, Section 10, 1st paragraph, line 3 and 2nd paragraph, line 4 and 5 be

AMENDED BY

striking in each, the word *APRIL* and substituting therefor in each line the word *MARCH*

CHAPTER XI, section 10, 1st paragraph would then read: "Any component society which fails to pay its assessment or make the annual report required on or before

March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the House of Delegates until such requirements have been met.

"A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of non-payment of dues, his membership is delinquent. If dues remain unpaid as of June 30th of the current year, membership shall be automatically dropped. . . .

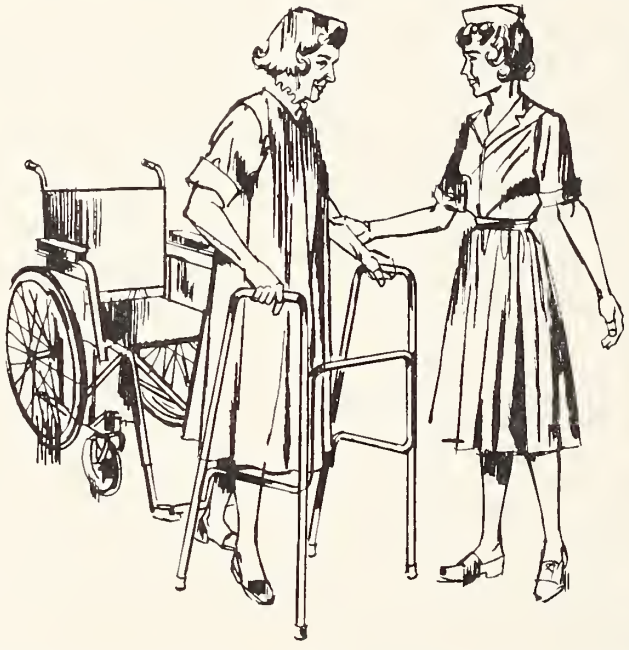
(J) A complaint was received from a trustee who had difficulty following the procedure that CHAPTER XII, DISCIPLINE is not clearly worded.

The committee has been assured by legal counsel that, as written the chapter contains all the safeguards required, and is not in conflict with law or court procedure. We do feel, however, that the organization of the chapter, where the sequence of the sections does not allow the reader a continuity of procedure thru the component society and the ISMS, does warrant rearrangement for clarity.

We will therefore propose to amend the bylaws in CHAPTER XII by rearrangement of the sections.

We are aware that a resolution may be submitted and referred to this committee and are prepared to make recommendations if it is referred to the reference committee or to us, and we are aware that the committee to study committees may come in with recommendations for extensive revisions of the committee structure, but expect that if it does, the matter will not be referred to us until the House meets for consideration next year.

Andrew J. Brislen, *Chairman*
David S. Fox — Charles J. Weigel
Wayne N. Leimbach — M. Mijanovich
Ex-Officio: Edward W. Cannady



ECONOMICS AND INSURANCE

COMMITTEE ON AGING
EI-1

During the past year the Committee on Aging placed emphasis on implementing the pilot program in District I, continued to encourage an active stroke program, cooperated with other member agencies of the Illinois Joint Council to Improve the Health Care of the Aged, and considered other programs for possible future implementation.

Under the direction of Dr. William K. Ford, rapid strides have been made toward implementing a successful program in District I. The Winnebago County Medical Society Committee on Aging sponsored the formation of a Council on Aging. This council, composed of representatives of many organizations and agencies interested in aging, has conducted several successful programs and has received much favorable publicity in the Rockford press. The purposes of the Council on Aging include: 1) Study of the Health Needs of the Area; 2) Coordination of the Activities of Organiza-

tions in this Field; 3) Cooperation with These Organizations and Agencies; 4) Dissemination of Information to the Public on Health Care of the Aging. This is the second county council formed under county medical society sponsorship, and it is hoped that other county medical societies will encourage the formation of similar councils or committees. Dr. Ford's committee has held several meetings to discuss programs for all counties of District I.

Upon the recommendation of the Committee on Aging, the Board of Trustees of the Illinois State Medical Society endorsed in principle the "Stroke Coordination Program," a pilot study of the Illinois Heart Association. The committee has had the pleasure of receiving progress reports from the chairman and coordinator of the program which is being conducted in Macon County with the cooperation of the Macon County Medical Society.

The film, "Stroke—Early Restorative Measures in Your Hospital," produced by the Committee on Aging in cooperation with the Illinois Department of Public Health, continues to attract considerable interest and has had world-wide distribution both in the Free World and behind the Iron Curtain. The film may be secured for viewing on a loan basis through the Committee on Aging of the Illinois State Medical Society or the Film Library of the Illinois Department of Public Health. The film will be available for Woman's Auxiliary meetings if a physician is present for discussion. Copies of the film may be purchased.

The committee cooperated with other member agencies of the Illinois Joint Council to Improve the Health Care of the Aged in sponsoring a program in Springfield on May 26, 1965, on "How Professional Disciplines Meet Patients' Needs in Long Term Care." Dr. Joseph Mallory, President of the Illinois Joint Council, and Dr. H. Close Hesseltine, Chairman of the National Council for Accreditation of Nursing Homes, participated in the program. The Conference was well attended by physicians and members of the Woman's Auxiliary. The fate of the Illinois Joint Council remains in doubt since the National Joint Council to Improve the Health Care of the Aged has been dissolved.

The committee continues to support the rehabilitation training of registered nurses provided through the support of the Illinois Department of Public Health. Scholarships and stipends for the course are now available to registered nurses employed in nursing homes in addition to hospitals.

Members of the committee continue to serve actively on numerous advisory councils and committees concerned with the problems of aging and chronic illness.

The Committee on Aging recognizes that there are many items worthy of special attention. These include formation of additional home care programs, cooperating with nursing homes for continued improvement of care and facilities, further efforts encouraging training of personnel in the rehabilitation of stroke patients, implementation of rehabilitation programs with the hospital by staff participation as outlined in a previous communication by the committee, education of older people, housing, recreation, retirement preparation and problems, and health maintenance programs. However, it is not possible for the committee to institute some of these programs without increased staff assistance. The services of a health educator would be very helpful but are not available at this time.

The committee desires to acknowledge the services of Mr. Walter R. Livingston and his secretary, Miss Gaylen Lair, for their assistance and cooperation in the work of the committee.

Edward W. Cannady, *Chairman*

Preston V. Dilts	Ernest G. McEwen
William K. Ford	Henry T. Rickets
Edward E. Gordon	Martin H. Seifert
Ray C. Johnston	Roger F. Sondag
Joseph R. Mallory	Thomas T. Tourlentes

Henry M. Wilson, Jr.

Auxiliary: Mrs. Howard A. Lowy

MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS DEPARTMENT OF PUBLIC AID
EI-2

Mr. Swank's report as Director of the Illinois Department of Public Aid will be found under the report of the Chairman of the Board of Trustees (AO-8).

The Medical Advisory Committee to the Illinois Department of Public Aid meets regularly on the Saturday preceding the Board of Trustees meeting. The Committee serves in an advisory capacity to the Department of Public Aid and furnishes the department with sub-committees such as those on Drug Manual, Ophthalmology, Anesthesiology, Radiology, and Cardiovascular Disease by communicating directly with members of the sub-committees for their recommendations on particular cases submitted to them for recommendation. The Sub-Committee on Ophthalmology met with the Medical Advisory Committee to review policy on participating optometrists treating public aid recipients.

The committee has worked consistently with the department to get payments approved for physicians who treat public aid patients in

Cook County hospitals. The committee is happy to report that physicians in Cook County since August 1, 1965, have been reimbursed on the same basis as physicians treating public aid patients outside Cook County.

In an effort to bring existing reimbursement allowances more in line with what is actually being charged private patients, your committee initiated preliminary discussions on fee revisions with Mr. Harold O. Swank, Director of the Illinois Department of Public Aid. Since then, the Board of Trustees took the position that in all government programs, federal, state, and local, physicians should be reimbursed according to their usual and customary fee without reference to existing payment schedules. Further follow-up on the society's position was assigned to the Committee on Usual and Customary Fees.

The committee, with the approval of the Board of Trustees, recommended to the department that interns and residents not be paid; and that no professional fees be paid to physicians in government hospitals.

The Illinois Department of Public Aid revised its policy to pay for duck embryo vaccine when it is requested by a physician and when the county medical advisory committee approves the request. The Department of Public Aid will not reimburse physicians using rabbit vaccine inasmuch as it is supplied free by the Illinois Department of Public Health.

The committee was informed by Mr. Swank that he had submitted a state plan for implementation of medical assistance under Title XIX of the Social Security Act. Title XIX of the Social Security Amendments of 1965 permitted states to move into a consolidated medical program January 1, 1966. The new program in Illinois will take care of the medical component of the federally aided programs of Old Age Assistance, Disability Assistance, Aid to the Blind, Aid to Dependent Children, and Medical Assistance for the Aged (Kerr-Mills). Title XIX also provides payment for medical care for a new group of individuals referred to as the near needy who are categorically related to the programs indicated above. As a result of implementing Title XIX January 1, 1966, it means an additional $1 million a month and an additional $20 million or more of federal funds coming into Illinois for the biennium. Mr. Swank informed the committee that a reason for moving into Title XIX was to increase federal matching funds from about 35% to 50%.

The advisory committee requested the opinion and advice of an ad hoc committee on the use and payment for intra-uterine contraceptive devices for public assistance recipients. The ad hoc committee, made up of Dr. H. Close Hesseltine, Chairman, Dr. Edwin DeCosta, and Dr. Newton DuPuy, recommended that:

(1) That those institutions and facilities now using IUCD's be authorized to continue their use for public aid recipients;

(2) That the Medical Director of the Illinois Department of Public Aid be empowered to authorize individual physicians to use the devices on a study and research basis;

(3) That physicians submit experience utilization reports during a six-month trial basis which will aid in gathering additional information to determine final policy recommendations for the committee to submit to the Department of Public Aid.

The committee was informed that the Memorial Hospital of Springfield has asked the department to pay for their inhalation therapy program, a one year course of treatment, for public aid patients with chronic lung difficulty. The Department of Public Aid asked the opinion of the committee as to whether this program would be considered an essential service and whether the program is an appropriate plan of care to be provided for public aid recipients. Members of the committee have looked into the program and informed the committee that the Memorial Hospital anesthesiology department is being asked to treat patients with emphysema, that they have worked out the program and figured out the cost so far as the accounting system allows them to do so. The committee was advised by its members to recommend payment for services provided public aid recipients on a trial basis for one year. The committee agreed and further recommended to the department that programs of a similar nature in other hospitals not be approved until an evaluation of the Springfield program is made. In addition, the committee recommended that each case be screened by the anesthesiology department before being accepted for the inhalation therapy program and that it submit to the Department of Public Aid a report on each recipient participating in the program during the one year trial period.

In 1965 it was reported to the House of Delegates that from time to time the state committee was confronted with problems concerning the quantity and quality of medical care being provided by physicians to public aid recipients. Under such circumstances the Department of Public Aid found it necessary to utilize lay personnel in contacting physicians and reviewing their practices. Consequently, the Medical Advisory Committee, with the approval of the Board of Trustees, recommended that physicians be engaged on a part-time basis by the department to go into the

offices of physicians and review their practice when there is a question about the care provided the public aid recipient. The Medical Advisory Committee recommended to Mr. Swank that only physicians be used for such purposes; that such physicians be engaged by the department as consultants; and that they be reimbursed for their services. Names have been submitted to Mr. Swank through members of the Board of Trustees and the committee has been informed that such consultants are being used by the Department of Public Aid in performing the function referred to above.

This is a report of progress and requires no action by the reference committee.

Fred A. Tworoger, *Chairman*
John H. Steinkamp, *Co-Chairman*

Charles E. Baldree — George T. Mitchell
Walter C. Bornemeier — Robert C. Muehrcke
James R. Cooper — Frank B. Norbury
Chauncey C. Maher, Jr. — William Scanlon
Rex O. McMorris — Frank P. Skaggs
R. Kent Swedlund

Consultants: Edwin S. Hamilton
George F. Lull
Burtis E. Montgomery

COMMITTEE ON DRUG MANUAL
EI-3

The Committee on Drug Manual has worked continuously and intensively to refine the list of drugs contained in the manual prepared at the request of the Illinois Department of Public Aid.

The committee's activities have been reported regularly to the State Medical Advisory Committee and to the Board of Trustees during the past year.

In keeping with the recommendation of the reference committee approved by the House of Delegates, the committee has continued to work with the Department of Public Aid in an effort to keep the drug list effective and up to date. The committee also recommended to the Department of Public Aid that the manual be reprinted in loose leaf form to facilitate future additions and deletions. This was approved by the department and the revised loose leaf manual was distributed in September, 1965.

During 1965, the committee reviewed 576 special written requests submitted to it by members of the society for drugs not listed in the manual. Of these 576, about 98% were approved, representing 560 requests.

The committee continues to review and approve or disapprove special requests made by physicians for drugs not listed in the manual. The committee evaluates the frequency with which a particular unlisted drug is requested and uses this as a guide in developing its recommendations for revision. A complete and accurate record of drug requests and committee action are kept in the society's office.

While the manual includes a wide variety of items and is thought to list the drugs required in the everyday practice of medicine, the committee does not look upon the Drug Manual as final. Continued experience and constructive criticism by the members has made it necessary to revaluate the list of drugs in the manual. As a result, many hours of tedious study and examination by the committee have been devoted to preparing a list of drugs subject to the approval of the Medical Advisory Committee and the Board of Trustees to be submitted to the Department of Public Aid for its approval, publication, and distribution to participating physicians. Such a list is planned to be submitted to the Board of Trustees, accompanied by a recommendation to the department that it be reproduced and mailed to participating physicians in the State of Illinois, subject to the board's approval. In so doing, the committee feels that it is fulfilling its obligation to the members in attempting to keep the drug list effective and up to date.

The committee appreciates the cooperation it has received from the members as a whole. It also appreciates the constructive criticisms which have assisted the committee in revising the current list of drugs and formulating its recommendation to the Board of Trustees and to the Department of Public Aid. Without this assistance and cooperation from the members the committee's task would have been insurmountable.

The committee welcomes suggestions and comments from the members and hopes they continue. The committee will be guided by sound therapeutic recommendations of the members when making future revisions of the Drug Manual for consideration by the Illinois Department of Public Aid.

Robert C. Muehrcke, *Chairman*
James A. Weatherly, *Vice-Chairman*

Charles R. Frazer, Jr. — Edsel K. Hudson
Theodore R. Van Dellen

Consultants: Theodore R. Therrod
Louis Gdalman

COMMITTEE ON REHABILITATION SERVICES
EI-4

The Committee on Rehabilitation Services had not met up to the time this report was submitted for publication in the *Illinois Medical Journal* on February 15, 1966. The com-

mittee nevertheless has as its continuing project the development of the Guide to Rehabilitation Facilities in Illinois, Listing Types of Disabilities Amenable to Rehabilitation. At the present time this information has been unavailable from a single source.

In the event the committee meets before the meeting of the House of Delegates and has firm recommendations for the House to consider a supplementary report will be filed.

Edward L. Compere, *Chairman*

Paul Richard Allyn — Rex O. McMorris
Henry B. Betts — Robert Dunham Moore
Eli Borkon — Daniel Ruge
Howard W. Schneider

Consultant: Reuben R. Wasserman
Ex-Officio: Frank J. Jirka

RELATIVE VALUE COMMITTEE
EI-5

Report to be filed at later date.

BLUE CROSS-BLUE SHIELD LIAISON COMMITTEE
EI-6

In 1964 the Blue Cross-Blue Shield Liaison Committee was appointed by the Board of Trustees for the purpose of providing a formal line of communication among the three groups —the Illinois State Medical Society, the Illinois Medical Service, and the Illinois Hospital Corporation—thereby keeping each group informed of ongoing and projected programs, changes in policy, and anticipated activities. In its effort to avoid overlapping activities of other state medical society committees which may have specific problems referred to them for action, the Blue Cross-Blue Shield Liaison Committee has not met since last reporting to the House of Delegates. Specific problems concerning the Illinois Medical Service and the Illinois Hospital Corporation have been referred by the Board of Trustees to the appropriate committees assigned to deal with such problems. The committee stands ready to carry out its function as liaison with these groups when the need arises and will so report to the Board of Trustees as is necessary.

Clifton L. Reeder, *Chairman*
Committee on Medical Economics

C. Elliott Bell,
Committee on Relative Value

Maurice M. Hoeltgen,
Committee on Prepayment Plans and Organizations

Daniel Ruge,
Committee on Medical Education

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS
EI-7

The Board of Trustees, at its October meeting, took the position that physicians should be reimbursed on the basis of their usual and customary fees when providing services to recipients of the Illinois Department of Public Aid, the Division of Vocational Rehabilitation; the Department of Children and Family Services; and the Military Dependents Medical Care Program, who presently pay for medical services on some type of fixed fee basis. Government agencies who will be asked to pay usual and customary fees will likely require a definite plan for adjusting differences when the fee submitted by the physician is regarded as unusual or unreasonable. As a result, the Board of Trustees assigned this responsibility to the Prepayment Plans and Organizations Committees which are elected by the House of Delegates and whose functions are listed in the Constitution under Chapter IX, Section 12, as follows:

Section 12. *Committee on Prepayment Plans and Organizations.*

The Committee on Prepayment Plans and Organizations shall consist of five members elected by the House of Delegates.

It shall review and adjust differences between members of the Society and prepayment plans and/or insurance organizations (including federal and state governmental programs), except those otherwise served by special advisory committees. In disputes brought by third parties against physicians, the committee shall act only upon referral or appeal from county or district committees.

The committee shall encourage county medical societies to establish appropriate committees to which third party grievances may be brought and to notify third party plan administrators of the existence of such local committees.

The committee may

A. recommend procedures for conducting hearings by county or district committees, and

B. develop guides consistent with the policy of the House of Delegates for county medical societies in their dealings with third party plans which pay "usual and customary fees."

In any dispute over fees between a physician and any third party plan involving a fee or benefit schedule negotiated by the Illinois State Medical Society, the committee may act in review at the member's request without referral from the county or district committee.

The committee shall consider

A. all problems bearing on the relationship between physicians and prepayment plans or health insurance carriers;
B. methods for increasing the effectiveness of existing prepayment and insurance plans;
C. proposals for the financing of medical care for all segments of the population, and
D. problems encountered by physicians in supplying services under the various certificates and policies, or in the reporting of claims.

After being notified of the decision of the committee, a member of the society shall have 30 days to appeal for a rehearing before the committee. If after careful investigation, the Committee on Prepayment Plans and Organizations finds that the complaint cannot be adjudicated amicably, the committee shall report the matter to the county society. If factors in the case warrant it, the committee may recommend that charges of unethical conduct be preferred against the offending member or that agreements with plans and organizations be revaluated.

Failure to appear on order of the committee may be grounds for citation of unprofessional conduct to the county society.

Under the foregoing provisions, the county medical society would retain the initial authority to act. The district and state committees would act upon appeal, upon request, or in the event the county committee fails to act. It would be desirable to have the county committee elected by the county medical society rather than appointed inasmuch as these committees must make impartial judgments in adjusting differences in usual and customary fees.

The Committee on Prepayment Plans and Organizations is also concerned with utilization review requirements under P.L. 89-97. The provisions of the law require hospitals and extended care facilities participating in the hospital insurance program (Part A, Title XVIII) to have in effect a utilization review plan providing for review, on a sample or other basis, of: Admissions of beneficiaries of the hospital insurance program to the institution; Length of stays; And the medical necessity for services provided.

Regulations would provide the institution some leeway in determining when the review would have to be carried out, and the point at which a review would be most appropriate might vary with the diagnosis and treatment involved.

The attending physician would have to be offered an opportunity for consultation with the physician-members of the review group before there could be a finding that a beneficiary's further stay in the institution is not medically necessary; the institution and the attending physician would have to be promptly notified of any such finding. Where such a finding has been made, the patient can make arrangements to continue to stay but the program would not make payment for services furnished the patient after the third day following the day on which the institution received notice of the finding.

Where reviews were not being made, the government could, in lieu of terminating the agreement under which the institution participates in the program, make a decision that the program would make payment only for the first 20 days of the beneficiary's stay in the case of a hospital, or only for days up to a specified number in the case of an extended care facility. Details will be spelled out in the regulations yet to be published by the Department of Health, Education, and Welfare.

The review would ordinarily be carried out by a staff committee of the hospital, which would have to include two or more physicians but which may include other professional personnel such as registered nurses and medical social workers. Such non-physician members as may be desirable could serve the committee as consultants or in an ex-officio capacity. Alternatively, the review could be conducted by a similar group outside the institution established by the county medical society and some or all of the hospitals and extended care facilities in the locality.

In some circumstances the review committee may have to be one outside the institution where the small size of the institution or the extended care facility lacked an organized medical staff.

There are many types of plans which can fulfill the requirements of the law. Hospitals wishing to establish their eligibility to participate in the program must submit a written description of their utilization review plan and a certification that it is currently in effect or that it will be in effect on July 1, 1966.

Cost incurred in connection with the implementation of the utilization review plan are includable in "reasonable" costs and are reimbursable to the hospital to the extent that such costs relate to health insurance program beneficiaries. Costs may include expenses incurred for the purchase of data from organizations outside the hospital which compile statistics, profiles, and study results on utilization of hospital facilities and services.

The following standards were published by the Department of Health, Education, and Welfare for the utilization review plan for hospitals as a condition of participation.

Standard A

The operation of the utilization review plan is a responsibility of the medical profession. The plan in the hospital has the approval of the medical staff as well as that of the governing body.

Standard B

The hospital has a currently applicable, written description of its utilization review plan. Such description includes:

- The organization and composition of the committee(s) which will be responsible for the utilization review function;
- Frequency of meetings;
- The type of records to be kept;
- The method to be used in selecting cases on a sample or other basis;
- The definition of what constitutes the period or periods of extended duration;
- The relationship of the utilization review plan to claims administration by a third party;
- Arrangements for committee reports and their dissemination;
- Responsibilities of the hospital's administrative staff.

Standard C

The utilization review function is conducted by one or a combination of the following:

- By a staff committee or committees of the hospital, each of which is composed of two or more physicians, with or without the inclusion of other professional personnel; or
- By a committee(s) or group(s) outside the hospital composed as above which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality; or
- Where a committee(s) or group(s) as described in the first or second paragraph of this standard has not been established to carry out all the utilization review functions prescribed by the Act, by a committee(s) or group(s) composed as in the first paragraph above, and sponsored and organized in such manner as approved by the Secretary of Health, Education, and Welfare.

Factor 1. The medical care appraisal and educational aspects of review on a sample or other basis, and the review of long-stay cases need not be done by the same committee or group.

Factor 2. Existing staff committees may assume the review responsibility stipulated in the plan. In smaller hospitals, all of these functions may be carried out by a committee of the whole or a medical care appraisal committee.

Factor 3. The committee(s) is broadly representative of the medical staff and at least one member does not have a direct financial interest in the hospital.

Standard D

Reviews are made, on a sample or other basis, of admissions, duration of stays, and professional services furnished, with respect to the medical necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services. Such reviews emphasize identification and analysis of patterns of patient care in order to maintain consistent high quality. The review is accomplished by considering data obtained by any one or any combination of the following:

- By use of services and facilities of external organizations which compile statistics, design profiles, and produce other comparative data; or
- By cooperative endeavor with the fiscal intermediary(ies) in the locality; or
- By internal studies of medical records.

Factor 1. Reviews of cases, based on diagnostic categories, include diagnoses of special relevance to the aged group.

Factor 2. Some review functions are carried out on a continuing basis.

Factor 3. Reviews include a sample of recertifications of medical necessity, as made for purposes of the Health Insurance for the Aged Program.

Standard E

Reviews are made of each beneficiary case of continuous extended duration. The hospital utilization review plan specifies the number of continuous days of hospital stay following which a review is made to determine whether further inpatient hospital services are medically necessary. The plan may specify a different number of days for different classes of cases. Reviews for such purpose are made no later than the seventh day following the last day of the period of extended duration specified in the plan. No physician has review responsibility for any extended stay cases in which he was professionally involved. If physician members of the committee decide, after opportunity for consultation is given the attending physician by the committee, and considering the availability and appropriateness of out-of-hospital facilities and services, that further inpatient stay is not medically necessary, there is notification in writing within 48 hours to the institution, the attending physician and the patient or his representative.

Factor 1. Because there are significant divergencies in opinion among individual physicians in respect to evaluation of medical necessity for inpatient hospital services, the judgment of the attending physician in an extended stay case is given great weight, and is not rejected except under unusual circumstances.

Standard F

Records are kept of the activities of the committee; and reports are regularly made by the committee to the executive committee of the medical staff and relevant information and recommendations are reported through usual channels to the entire medical staff and the governing body of the hospital.

Factor 1. The hospital administration studies and acts upon administrative recommendations made by the committee.

Factor 2. A Summary of the number and types of cases reviewed, and the findings, are part of the records.

Factor 3. Minutes of each committee meeting are maintained.

Factor 4. Committee action in extended stay cases is recorded, with cases identified only by hospital case number.

Standard G

The committee(s) having responsibility for utilization review functions have the support and assistance of the hospital's administrative staff in assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, and promoting the most efficient use of available health services and facilities.

Factor 1. With respect to each of these activities, an individual or department is designated as being responsible for the particular service.

Factor 2. In order to encourage the most efficient use of available health services and facilities, assistance to the physician in timely planning for post-hospital care is initiated as promptly as possible, either by hospital staff, or by arrangement with other agencies. For this purpose, the hospital makes available to the attending physician current information on resources available for continued out-of-hospital care of patients and arranges for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge of a patient.

The committee is in the process of developing Guidelines for Utilization Review and will make it available to members when it is completed. If the regulations are published prior to the meeting of the House of Delegates, your committee will file a supplementary report.

Maurice M. Hoeltgen, *Chairman*
Philip C. Lynch — H. Kenneth Scatliff
Michael R. Saxon — E. Lee Strohl

COMMITTEE ON MEDICAL ECONOMICS
EI-8

Two principal areas of concern occupied the committee's attention since the 1965 meeting of the House of Delegates: 1) Reviewing the society sponsored major medical program; the disability program; and the retirement-investment program; and 2) Investigating the possibility of sponsoring a group life insurance program for members of the Illinois State Medical Society.

The open enrollment of the Group Major Medical Expense Plan extended from April 1 to August 1, 1965. This brought in an increase in the number of assured sufficient to waive prior medical history for new applicants. The Group Major Medical Expense Plan became effective August 1, 1965, at which time the open enrollment period was closed. However, the company agreed to the committee's request to grant new members the opportunity to enroll in the program without evidence of insurability within a period of six months after becoming a member of the society. The experience with the major medical program for the first six months it has been in effect has been very favorable.

Your committee has been vitally concerned with the effect P.L. 89-97 (the Medicare Law) will have on the Group Major Medical Plan for subscriber-members over age 65. Your committee has been informed that changes, if any, would be as of the next renewal date, August 1, 1966, and would be in consultation with the committee. The committee is working closely with the insurance company so that it will be in a position to help formulate any changes that might be necessary as a result of the Medicare Law. You can be sure that your committee is giving this matter its concerted attention.

New policies have been issued for the Disability Plan from April 1, 1965, to February 1, 1966, as a result of new members joining the society. The committee is pleased that the experience of the Group Disability Program has been favorable. The committee has approved the request of Parker, Aleshire & Co., the program administrator, to open its enrollment period again from April 1, 1966, to June 1, 1966.

The Society's Tax Qualified Retirement Program (Keogh) was offered to the membership in December, 1964. The basic Retirement-Investment Program was offered to the membership in March and April, 1965. The dollar

investments as of December 31, 1965, in the Retirement-Investment Program totaled about $264,000. The Tax Qualified Program, as of December 31, 1965, reached $131,708, bringing the total investments to about $395,708. At the member's choice, monies are presently being invested in a group annuity through the Continental Assurance Company and/or the Stein, Roe, Farnham, Inc. mutual stock fund.

After the initial enrollment period was closed in April, it was found that less than 100 members were investing in the group "insured" annuity. This was the minimum requirement to guarantee the issuance of a $10,000 death benefit without medical examination. At the request of your committee, the Continental Assurance Company re-opened its enrollment period in an effort to reach the 100 minimum subscribers necessary to waive prior medical history. Because this number was not reached even on the second enrollment period, it was necessary for Continental Assurance Company to offer the following alternatives to those with impaired risks: 1) Issuance of the group insured annuity contract as applied for, subject to medical examination; 2) Issuance of a group insured annuity without an insurance death benefit, without medical examination; 3) Full refund of premiums paid.

The company and the committee are pleased with the progress of both the basic Retirement-Investment Program and the Tax-Qualified Program. The average investment is very high compared with other professional associations and it can be reasonably expected that participation will increase substantially in the years to come as the membership becomes more aware of the advantages of these programs made available to it through the continuous investigation of your committee.

Your committee anticipates another open enrollment period for the Retirement-Investment Program in the fall of 1966, allowing sufficient time after the open enrollment period for the Group Disability Program.

Your committee feels that it would be to the advantage of the membership to offer to it the opportunity to enroll in a group life program sponsored by the society. At the present time the committee is investigating the possibility of recommending a group life insurance program for members of the society and has met with individuals who have indicated their interest in submitting such a plan to the society. At the time of filing this report, the committee has not formulated a recommendation to the Board of Trustees for its consideration. However, if such a recommendation is formulated and submitted to the board, the committee will submit a supplementary report to the House of Delegates at its annual meeting.

In response to Resolution 31, passed by the 1965 House of Delegates, the committee proceeded to have deleted payment for blood, blood derivatives, and other human tissues from the Group Major Medical Expense Plan contract sponsored by the state medical society for its members. Upon further investigation, the committee has been informed that payment for blood and blood derivatives is not included in existing health insurance contracts sponsored by county medical societies in the state of Illinois.

The Committee on Medical Economics feels that it is fulfilling its obligation to the society by reviewing the society's sponsored insurance programs and investigating the possibility of developing still other programs for the benefit of its members.

This is a report of progress and no action is required of the reference committee.

Clifton L. Reeder, *Chairman*

Maurice M. Hoeltgen — F. Paul LaFata
John J. Holland — Philip C. Lynch
Lawrence J. Knox — Robert E. Schettler
Frederick Z. White

COMMITTEE ON HOSPITAL RELATIONS EI-9

The Committee on Hospital Relations met with the Illinois Hospital Association to discuss ways in which follow-up could be undertaken on Resolution 65M-29, adopted by the House of Delegates, which directed the study of emergency room service. It was agreed by both committees that the topic to be explored in detail at the Seventh Joint Conference of the Illinois State Medical Society and the Illinois Hospital Association be "Emergency Room Service in Illinois Hospitals." The conference will be held in Springfield at the St. Nicholas Hotel, 9 a.m., Thursday, April 21. Due to the importance of the subject, invitations will be extended to chiefs of hospital staffs, administrators, directors of nursing, hospital trustees, and emergency room supervisors. Attendance is open to all interested members of the Society and allied groups, and is not limited to any of the groups mentioned above.

The morning session will be devoted to a discussion of the topic in general with time allowed for questions and answers. Following the morning session, the conference will adjourn for luncheon during which time the speaker will summarize the morning session and throw out provocative questions for the participants to consider at the eight workshop sessions in the afternoon, each dealing

with a single facet of emergency room service. Following the workshops, the general assembly will reconvene for the program wind-up before adjournment at 4 p.m.

The committee feels that by devoting a full day to a statewide conference on the subject of emergency room service, it is fulfilling its obligation to the House of Delegates to study the problems of emergency room care.

The committee has also explored the idea of having one regional hospital center provide emergency room services which may also serve to alleviate the problem of staffing all hospital emergency rooms. The committee will report to the Board of Trustees at a time when its recommendations have been formulated.

The committee is continuing to lend assistance to the hospital association in its efforts to accredit non-accredited hospitals. All but 33 of the state's 272 general hospitals are now accredited. The most common obstacles to accreditation include incomplete or inadequate medical records; failure of the staff to review the medical work of its members; obsolete staff by-laws and/or failure to comply with their requirements; and failure of the governing board to delineate physicians' privileges according to staff committee recommendations.

The committee recommended and the board approved that it be represented on an ad hoc committee made up of legal counsel of the Illinois State Medical Society; representatives from the Illinois Hospital Association; Mr. Harris Rowe and Attorney Dirksen, representing the insurance industry, along with two other industry representatives recommended by the Health Insurance Council for the purpose of developing guidelines for hospitals and the insurance companies governing the release of medical record information.

This is a report of progress and does not require action by the reference committee.

Noel G. Shaw, *Chairman*

John A. Bowman	Harlan English
J. W. Buser	Kenneth John Smith
John M. Dorsey	N. A. Thompson

Ex-officio: Casper Epsteen

COMMITTEE ON FEE SCHEDULES
EI-10

The Committee on Fee Schedules prepared a 50-page report outlining basic policy of the state society regarding medical care for the needy; AMA policy on fee schedules; procedures followed in other states; and a table comparing government fee schedules used in Illinois. The report was prepared to guide the committee in developing recommendations to the Board of Trustees with regard to fee schedules in view of social security legislation.

Tax-financed health programs have become increasingly important to the medical profession in recent years. In Illinois about 400,000 persons of all ages, about 4% of the total population, receive public aid for a total health expenditure of $85,000,000; $7,650,000 of which is partially paid for physicians' services. With the enactment of P. L. 89-97, the Medicare Law, another 10% of the total population in Illinois became eligible for certain health care benefits. Because of federal legislation, the committee declined to recommend to the Board of Trustees approval of any fee schedule for fear it would compromise the bargaining position of the society in its future dealings with the federal government.

Each year since the Dependents Medical Care Program was implemented in Illinois, the state society has entered into a contract with the U. S. Government, Office for Dependents Medical Care. The fiscal administrator of the program is the Illinois Medical Service (Blue Shield). The contract expired July 31, 1965, and had to be renewed before the government would send funds to Blue Shield to reimburse Illinois physicians. The committee recommended to the board and the board agreed that the contract should not be negotiated for the usual one year period as it could prejudice future dealings with the government over reimbursements for medical care under social security. The committee recommended and the Board of Trustees approved that the existing contract be extended for periods of 90 days until such time as the society takes action with reference to all fee schedules.

Dr. J. Keller Mack, Medical Director for the Department of Children and Family Services, on July 12, 1965, wrote to the Committee on Fee Schedules seeking approval of the department's rules and regulations for physicians' reimbursement. Dr. Mack met with the committee on July 15 and was informed that before the committee could make any recommendations it would have to seek approval from the Board of Trustees.

The committee informed Dr. Mack that it would recommend approval to the board with the following provisions:

1. That the Department pay 80% of the physician's usual and customary fee and eliminate all reference to the Relative Value Study in the rules and regulations of the department;
2. That the department refer fee disputes to an appropriate committee of the county medical society thereby utilizing the mechanism established at the county, district, and state levels for resolving such disputes;

3. That the approval of any such fee arrangement would be only until December 31, 1965.

Dr. Mack agreed with these recommendations. The committee then recommended and the Board of Trustees approved a schedule of allowances for the Department of Children and Family Services of Illinois until December 31, 1965, at the rate of 80% of the physician's usual and customary fee.

In the process of developing its reports to the Board of Trustees, the committee was guided by the principle that when the need factor is removed from tax supported medical programs, there is no justification for physicians to treat such patients for less than their usual and customary fee or at no fee. By removing the element of need from such programs the incentive for physicians to continue voluntarily to conserve public funds by accepting substandard payments is automatically eliminated.

At its October meeting the Board of Trustees adopted the principle of usual and customary fees as the method of paying physicians for services rendered to patients receiving assistance through tax supported programs. Follow-up on board action on usual and customary fees has been assigned to the Committee on Usual and Customary fees and will be included in its annual report to the House.

This is a report of progress and requires no action by the reference committee.

George F. Lull, *Chairman*

C. Elliott Bell Franklin J. Moore (deceased)
Maurice M. Hoeltgen Carl F. Steinhoff

COMMITTEE ON USUAL AND CUSTOMARY FEES

(Formerly the Committee to Meet With the Illinois Medical Service And Other Potential Carriers Under P. L. 89-97)

EI-11

The Board of Trustees, at its meeting October 23, 1965, appointed a committee to meet with the Illinois Medical Service and other potential carriers and intermediaries under P.L. 89-97. The Department of Health, Education, and Welfare was required by law to name a carrier or carriers as fiscal administrators for Part B of Title XVIII of the Social Security Act after reviewing carriers recommended by organizations such as state medical societies. Part B, the voluntary insurance portion, will provide payment for physician's services to the age group over 65 who sign up for the program. The American Medical Association endorsed Blue Shield as an organization competent to perform the intermediary function but left such recommendation to the individual state or appropriate local medical society.

The Committee, after two meetings with potential carriers under Title XVIII, Part B, generally agreed that many were well qualified on the basis of experience to administer Part B of P. L. 89-97, and would be acceptable to the society as fiscal intermediaries. Discussions with private insurance companies as well as the cumulative experience of the committee members in their personal dealings with companies, led the committee to recommend to the Board of Trustees that no preferential treatment be given a single potential intermediary by the Illinois State Medical Society making a specific recommendation to the Department of Health, Education, and Welfare. The committee's recommendation to the board was predicated on the assumption that the Illinois State Medical Society would be in a better position to discuss the ramifications of the program's administration with the intermediary if no effort was made to influence the intermediary's designation which had to be made, under the law, by the Department of Health, Education, and Welfare. The board concurred in the committee's recommendation.

At the request of the Executive Committee of the Illinois State Medical Society, the committee was assigned the further responsibility of carrying out the position of the Board of Trustees on usual and customary fees. As a result a letter was prepared by the committee which set forth the society's position on usual and customary fees and mailed to all governmental agencies (the Illinois Department of Public Aid, the Division of Vocational Rehabilitation, the Veterans Administration, the Military Dependents Medical Care, and the Division of Children and Family Services) which pay for medical services on some type of a fixed fee basis. A copy of the letter which also requested the opportunity to meet with the above agencies, was mailed to officers of county medical societies and was subsequently reproduced in the "Government Medical Services Bulletin" which was mailed to all members of the society.

In connection with further discussion with the above agencies, the Board of Trustees, at its January 16, 1966, meeting, authorized the committee, if necessary, to employ professional negotiators to carry out the above objectives.

In addition, the committee was assigned the responsibility of defining the precise meaning and proposed application of usual and customary fees. After reviewing existing American Medical Association and Illinois State Medical Society policies as well as actions by other

state medical societies, the committee recommended to the board and the board agreed to the following definitions of usual, customary, and reasonable.

Usual—The "usual" fee is that fee usually charged for a given service, by an individual physician to his private patient (i.e., his own usual fee).

Customary—A fee is "customary" when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county).

Reasonable—A fee is "reasonable" when it meets the above two criteria, or in the opinion of the responsible local or district and state medical society review committee, is justifiable, considering the special circumstances of the particular case in question.

Inasmuch as government agencies are being asked to reimburse on the basis of usual and customary fees, the committee felt that the agencies would also require a definite plan for adjusting differences of disagreements that may result from such a policy. As a result your committee and the board reaffirmed its position that the Prepayment Plans and Organizations Committees, as elected by the House of Delegates for the districts and state levels, would provide the appropriate mechanism for the review of such cases when necessary and to serve as well as an appeal mechanism for members and third party carriers.

Although such committees are elected by the House on the district and state level, such committees would be established on the local level preferably by election by individual county medical societies. The functions of the committee are outlined in detail in the Constitution and Bylaws. Under the provisions detailed in the constitution, the county medical society would retain the initial authority to act. The district and state committees would act only upon appeal, upon request, or in the event the county committee failed to act.

The committee on Usual and Customary Fees is scheduled to meet again before the annual meeting of the House of Delegates but after this report has been submitted to the *Illinois Medical Journal* for publication. It is therefore anticipated that the Committee on Usual and Customary Fees will have a supplementary report to the House to inform it of the progress it has made in discussing usual and customary fees with carriers under Part B of Title XVIII of the Social Security Act and with government agencies.

The members should be aware that the law provides two methods of payment to physicians under Part B and that it is up to the physician and his patient to decide which method is used. Method 1 allows the physician to bill the patient direct, in which case the patient is fully responsible for the full payment of the obligation. After the patient has received a receipted bill from his physician he will send it to the carrier who, in turn, will reimburse the patient according to standards indicated below. Method 2 allows the physician to accept an assignment of benefits in which case he will bill the carrier and be reimbursed by the carrier directly.

Under either method, the carrier will pay 80% of what it determines is the reasonable and customary charge for the services rendered less the $50 deductible which is the responsibility of the patient. The balance will be paid directly to the patient if the patient has sent in the receipted bill in accordance with Method 1, or the balance will be sent directly to the physician if he has accepted an assignment of benefits in accordance with Method 2.

When the physician agrees to an assignment under Method 2, he must accept the reasonable charge determined by the carrier as his full fee, except that he may collect from the patient the remaining 20% of the reasonable charge and any or all of the $50 deductible the patient has not paid.

If the physician chooses Method 1 and bills the patient direct, he is under no obligation to accept anything less than what he bills his patient. It is the responsibility of the patient to meet the obligation of the physician's bill.

In following the directions contained in Resolution 25 of the 1965 House of Delegates, the Committee on Usual and Customary Fees mailed a letter to the Illinois Department of Public Aid setting forth the position of the Society with regard to usual and customary fees (referred to above). The committee is in the process of scheduling a meeting with Mr. Harold O. Swank, Director of the Illinois Department of Public Aid, prior to the meeting of the House of Delegates but after this report has been filed, to pursue discussions on fees that were initiated by other committees of the society.

Your committee feels that the recommendations of your committee and the actions of the Board of Trustees with regard to usual and customary fees should be affirmed by the House of Delegates.

Philip G. Thomsen, *Chairman*

George F. Lull — V. P. Siegal
Joseph R. O'Donnell — Francis W. Young

Ex-officio: Burtis E. Montgomery
William E. Adams — Caesar Portes



LEGISLATION AND PUBLIC AFFAIRS

LEGISLATIVE COMMITTEE LP-1

Meetings. Following customary practice, the committee has met on the Saturday afternoon preceding each meeting of the Board of Trustees. This has involved meetings in July, October, January, and March. Additional meetings will be held during the annual meeting. The chairman reports all significant legislative developments to the Board of Trustees on these occasions.

Newsletter. Customarily, highlighting legislative developments are reported to the membership each month via the *Illinois Medical Journal* insert page, "Legislative Listening Post." This was done through the December issue. In December it became necessary to report on the implementation of Medicare and other governmental programs in more detail and at irregular intervals. Accordingly, on December 10, the first issue of a new newsletter titled "Government Medical Care Bulletin" was issued to key physician leaders such as county medical society officers, legislative and public affairs chairmen, ISMS Board members, delegates, etc. In January the Board of Trustees authorized expansion of this mailing list to the entire membership, and the February issue was so distributed. To conserve funds, it became necessary to discontinue the monthly *Journal* insert temporarily in favor of the widespread distribution of the new bulletin.

National Legislation Summary. The first session of the 89th Congress will undoubtedly go down in history as the one which brought about the greatest intrusion of government into the health care field. The following tabulation, prepared by the AMA Legislative Department, lists 18 legislative proposals with medical significance which were enacted.

Health Legislation Enacted
89th Congress, First Session

Public Law	*Description*	*Bill No.*
89-4	Appalachian Regional Development Act. Among other things, provides grants for demonstration health facilities and sewage treatment works.	S. 3
89-73	Establishes an Administration on Aging in the Department of Health, Education, and Welfare.	H.R. 3708

89-74 H.R. 2
Drug Abuse Control Amendments. Provides for the control of depressant, stimulant, and counterfeit drugs.

89-92 S. 559
Federal Cigarette Labeling and Advertising Act. As of January 1, 1966, requires a caution statement on cigarette packages.

89-97 HR. 6675
Social Security Amendments of 1965. Contains: (1) a Social Security hospital insurance program for the aged, and a voluntary, supplementary medical insurance program; (2) a new medical assistance program for public assistance recipients; (3) amendments to the Maternal and Child Health and Crippled Children's programs; (4) extension of public assistance to aged persons with TB and mental illness; (5) amendments to the Social Security Act, including compulsory coverage of physicians and increases in the taxable wage base and tax rate; and (6) increased federal contributions for public assistance.

89-105 H.R. 2985
Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments. Provides grants for initial staffing of community mental health centers.

89-109 S. 510
Community Health Services Extension Amendments. Among other things, extends the Vaccination Assistance Act of 1962, the program of family health service clinics for migratory workers, and the Community Health Services and Facilities Act of 1961.

89-115 H.R. 2984
Health Research Facilities Amendments. Extends the health research facilities construction program.

89-234 S. 4
Water Quality Act. Transfers administration of water pollution control program from Surgeon General of PHS to Secretary of HEW and creates a Federal Water Pollution Control Administration.

89-236 H.R. 2880
Amends immigration law to, among other things, allow the admission of "professional" aliens, certain mentally retarded, and epileptics.

89-239 S. 596
Heart Disease, Cancer, and Stroke Amendments. Authorizes grants for the establishment of regional medical programs.

89-272 S. 306
Clean Air Act amendments. Provides for the control of air pollution from motor vehicles, and establishes a research and development program for the disposal of solid wastes.

89-288 H.R. 7484
Provides for the rank of Lieutenant General or Vice Admiral for the Surgeons General of the armed forces.

89-290 H.R. 3141
Health Professions Educational Assistance Amendments. Contains: (1) a new program of improvement grants for medical schools; (2) a scholarship program for medical students; (3) an extension of the medical school construction program; and (4) an extension of the student loan program.

89-291 S. 597
Medical Library Assistance Act. Establishes grant programs for the construction and equipment of facilities, training of personnel, and establishment of regional medical libraries.

89-294 H.J. Res. 571
Authorizes the President to proclaim the week of October 25, 1965, as "National Parkinson Week."

89-311 H.R. 168
Among other things, provides for the defense of certain malpractice claims against V-A physicians and other medical personnel, and establishes a ceiling for hospital and nursing home beds.

89-333 H.R. 8310
Vocational Rehabilitation Act Amendments. Provides grants for vocational rehabilitation services, construction of facilities and workshops, and training services, among other things.

Adopted by both Houses S. Con. Res. 30
Commemoration of tenth anniversary of Salk polio vaccine.

As previously indicated, your ISMS committee works in close conjunction with the AMA on national legislation. It is our policy to support the legislative position of the AMA except in those instances where the ISMS membership dictates a contrary position. During the first session, AMA testified or submitted statements on 17 subjects. Of these,

the testimony was in support on eight issues, in clear opposition on five, and either partially for or partially against on the remaining four. This record of support may come as a surprise to some who have been led to believe that the position of the AMA is always in opposition to legislation.

Political Disaster. The two major bills enacted in 1965, insofar as the threat to private medicine is concerned, were the Social Security Amendments of 1965 (Public Law 89-97) and the bill to establish regional programs on heart disease, cancer and stroke (Public Law 89-239). The outcome on the former, of course, is well known to all physicians. Government-subsidized medical care, commonly referred to as Medicare, will become a reality July 1, 1966. Likewise, the heart disease, cancer and stroke amendments were enacted into law, but only after vigorous opposition by the medical profession forced some twenty amendments which seriously altered the scope of this legislation and changed many undesirable features of the original bill.

There can be no doubt that medicine suffered badly at the hands of the liberals and the social planners in the first session of the 89th Congress. An additional 10 per cent of the private practice of medicine was transferred from the private sector to the public sector by the passage of Title XVIII of the Medicare bill. It remains to be seen what percentage will be transferred under the broadened scope of public aid medical care embodied in Title XIX. On the positive side, it is well to remember that the majority of medical care still remains in the private sector. A clearcut case was not established for the need of a government subsidy for all of the people 65 years of age and over. The vote to recommit the Medicare bill, which was the really decisive vote, gained support from 191 members of the Congress, including 63 of the administration's own party. This is one of the highest opposition scores recorded on any major issue in the first session. A switch of somewhere between 18 and 23 votes would have spelled victory. It is well to remember that Medicare was a dead issue in the 88th Congress in September of 1964. The supporters of the King-Anderson bill could not move the bill out of committee. In November this situation was altered drastically. In January of 1965, with the opening of the first session of the 89th Congress, Medicare was the number one issue. The Medicare battle was lost not because medicine's basic position was wrong or its legislative effort totally ineffective. Physicians were the victims of a political maneuver bordering on a near catastrophe to the two-party system and the conservative cause. As was reported to you in the supplemental report of this committee at the 1965 House of Delegates, this loss was made possible by the votes of Congressmen who were put into office by the voters on November 3. The issue was decided when the Congress was elected, not when it actually voted. The future of private medicine depends not only upon an aggressive legislative program but upon our ability to reverse this trend in the public affairs arena.

Controversy Resolved. With the enactment of Medicare, the dialogue centered on the appropriate position for physicians to take regarding its implementation. At the meeting of the AMA House of Delegates in New York in June, a controversy began which resulted in a special called session of the AMA House of Delegates in Chicago, October 2 and 3. As a result of the October meetings, much of the controversy was resolved. It was agreed that medicine had no logical alternative except to do its best to cooperate with the government in making a bad law work without prejudicing the case of any individual physician who desires not to participate, and reserving the right at any time to seek changes in this legislation. Your committee is particularly proud of the excellent job done by Dr. Burtis E. Montgomery, who served as chairman of the reference committee for this special meeting.

Broad Scope of PL 89-97. The term "MEDICARE" is generally applied to that part of the 1965 Amendments to the Social Security Act (P.L. 89-97) which establishes two new medical programs for the aged. The Social Security Act is a complicated law which includes numerous welfare programs in addition to the cash benefits program for persons retired from the labor force. The 1965 Amendments make numerous changes in the entire act. The changes of prime concern to medicine fall into four general categories:

1. Physician coverage under Social Security;
2. Changes in the welfare programs involving crippled children and mentally retarded children;
3. Title XVIII, which establishes two new subsidized medical care programs for the aged, the hospital program (Part A) and the voluntary supplemental medical program (Part B).
4. Title XIX, which makes major changes in the medical care section of the existing public aid programs.

No attempt will be made in this report to cover these extensive changes in detail. As a highlighting feature on physician coverage under Social Security, many physicians may have been shocked to learn on April 15 that they were required to pay $259.20 in Social Security taxes for calendar 1965. In 1966 this

increases to $405.90; and, from then on, it rises steadily to $514.80 by 1987, assuming no further increases enacted by Congress during the interim. The changes in the welfare programs for children basically involve increased appropriations for expanding existing programs. Title XVIII is discussed in detail later.

Title XIX, a new title added by the 1965 amendments, consolidates the present varied medical programs for differing categories of public aid into a single program for those who receive cash grants. It also permits establishment of a single program for the medically needy or non-grant category. The program is geared to a gradual escalation of benefits and coverage so that by 1975 the needy and medically needy of all ages will be covered by comprehensive medical benefits under public aid. Realistic eligibility requirements must be established, and children's responsibility for the medical care of aged parents is eliminated. Public aid is expected to reimburse physicians and others who provide services at realistic going rates. Some elements of Title XIX were instituted in Illinois by the Department of Public Aid, January 1, 1966. A two-day conference on Title XIX, sponsored by AMA, was held in Chicago in January, which several members of your committee attended. Further details of these changes will be covered under the reports of the Advisory Committee to Public Aid and the Ad Hoc Committee on Usual and Customary Fees.

Committee Assigned Responsibility. At the July meeting of the ISMS Board of Trustees, your committee was assigned the responsibility of monitoring progress on the implementation of P.L. 89-97 and charged with the responsibility of advising the Board of Trustees on an appropriate course of action. Accordingly, the staff was mobilized for research into the various facets of this broad legislation; and, at the October meeting of the Board of Trustees, the committee rendered a detailed report. The report included eight specific recommendations for adoption, as follows:

I. Participation versus Nonparticipation: Your committee recommends that the action taken at the special session of the AMA House of Delegates, October 3, be reaffirmed. This position, as interpreted, states (1) that an individual physician, acting independently and not in concert with others, may lawfully and ethically elect to treat or not to treat persons under the Medicare program; (2) that medicine will oppose any program which will interfere with the physician's freedom of choice with respect to participation or the acceptance of financial arrangements under which he shall provide care.

II. Certification - Recertification - Utilization Review: Your committee recommends that the actions taken at the special AMA House of Delegates, October 3, be reaffirmed. These actions would require that current practices and customary procedures with respect to certification of hospital admission and care should be continued under Public Law 89-97 and that hospital utilization committees should be composed of practicing physicians.

III. Carrier: Your committee recommends that the Board of Trustees appoint a three-man committee to meet with Illinois Medical Service for further information and with other potential carriers under P.L. 89-97 as deemed necessary in the judgment of the committee.

IV. Specialty Billings: Your committee recommends that the position adopted at the AMA special House of Delegates, October 3, be concurred with. This action, as interpreted, states that the charges for the services of hospital-based specialists should be billed and collected in the same manner as are the fees of other physicians. Your committee further recommends that the AMA position to vigorously resist efforts to change this provision in the law be supported. Your committee recommends that further coordinating meetings with the Illinois specialty groups in this category be sponsored.

V. Physician Payment: Your committee recommends that ISMS concur in the actions of the AMA special House of Delegates and that the ISMS membership be fully informed as to the provisions of the law and their rights regarding payment.

VI. Public Aid and Other Governmental Payments: Your committee recommends that a policy be adopted which provides that all governmental programs, federal and state, reimburse physicians according to the usual and customary fee within the community without reference to any existing payment schedule as a basis. Reaffirming the existing ISMS position that medical programs be administered by medically oriented personnel, your committee recommends that the medical aspect of Title XIX and Title II of PL 89-97 be administered by the Illinois Department of Public Health.

VII. Coordination on Medicare: Your committee recommends that ISMS join with the Illinois Hospital Association in establishing a coordinating committee with the key voluntary and governmental agencies most involved in Illinois. It is recommended that membership on this committee, in addition to the two sponsoring organizations, include the Illinois Nursing Home Association, Illinois Homes for the Aged, Blue Cross and Blue Shield, Hospital Planning Council of Metropolitan Chicago, the Departments of Public Health, Mental Health, and Public Aid, and the Division of

Vocational Rehabilitation, plus other groups as the committee deems necessary.

VIII. Continued Study: Your committee recommends that the Committee on Legislation or some other committee be assigned to conduct the continuing study of all facets of the administration of P.L. 89-97 and its implementation and report to the board at regular intervals.

By formal action, the Board of Trustees adopted all of these recommendations and charged the committee with the responsibility for further surveillance of Medicare developments. (As of the date of the preparation of this report, this surveillance continues, and additional details will be reported to the House of Delegates by supplemental report immediately prior to or at the meeting of the House of Delegates.)

Title XVIII—Medicare Implementation

AMA Advisory Role. Administration of the Medicare program is vested in the Department of Health, Education and Welfare (HEW), John W. Gardner, secretary. Within the department, the responsibility is further divided between the Social Security Administration, the Public Health Service, and the Welfare Administration. The law provides for a statutory advisory group known as the HEALTH INSURANCE BENEFITS ADVISORY COUNCIL (HIBAC). In developing the implementing rules and regulations, Secretary Gardner has called upon numerous voluntary agencies for assistance. The AMA has played a leading role in this advisory function through the formation of a special advisory committee which meets at intervals with the secretary and his key staff and through membership on numerous technical advisory committees established by HEW to deal with specific areas of implementation. Your committee is most pleased that one of its members, Dr. H. Close Hesseltine, has been selected to serve on Technical Advisory Committee #3, Provider Participation. Other Illinois members on the technical advisory committees are Dr. Hugh T. Carmichael, Chicago, Committee #6, Psychiatric Services; and Dr. Joseph L. Kocsur, Chicago, Committee #5, Specialists' Services. Dr. Samuel R. Sherman, California, chairman of the AMA Legislative Council, serves as a member of the statutory Health Insurance Benefits Advisory Council. Through this advisory mechanism, physicians' opinions have been expressed effectively in the development of implementing regulations.

Potential Problem Areas. Each of the new programs under Medicare contains at least one major problem area insofar as all participating physicians are concerned. Under the hospital program, Part A, this involves the special requirement for utilization review and the necessary certification by the physician for continued payment of benefits. Under Part B, voluntary supplemental medical program, the potential problem area concerns the method for compensating physicians. These special areas are under study by the Prepayment Plans and Organization Committee and the Ad Hoc Committee on Usual and Customary Fees, respectively. Further details will be found in the reports of those committees.

Hospital-Based Specialists. Under P.L. 89-97, all physicians' services except those of interns and residents in approved training programs must by law be reimbursed under Part B, the voluntary medical insurance program. Since many of the hospital-based specialists currently permit their services to be billed as hospital charges, changes in methods of operation will be required. ISMS, in August, invited representatives of the various professional groups representing radiology, pathology, physiatry, and anesthesiology to seek a coordinated approach to their problems. The anesthesiologists declined this invitation on the grounds that a majority of their members were currently billing patients on a direct basis. The remaining three groups welcomed the opportunity to act jointly and to gain support from all physicians in their fight to remain free of direct governmental control.

The national and state hospital associations have generally disagreed with this provision in the law. Originally, the hospitals sought a change in the law through an amendment submitted by Senator Paul Douglas. Later, the American Hospital Association withdrew its opposition, preferring to depend upon HEW to draft the regulations in a manner which would preserve existing arrangements. In January HEW issued, in preliminary form, a set of guiding principles for paying hospital-based specialists. These principles provide for an administrative component, to be paid for under Part A, and a professional component, to be reimbursed under Part B. Principle #3 made it clear that only identifiable services requiring performance by a physician for a specific patient would be considered as the professional component. This seriously limited the amount of services which pathologists could charge to Part B under the usual arrangements and immediately brought forth the charge that the intent of the law was being circumvented by the regulations. The principles do, however, permit payment under Part B when the pathology department is taken over and operated by the pathologist. Accordingly, the College of American Pathology is now advocating that course of action.

In Illinois the aforementioned groups repre-

senting pathology, radiology, and physiatry have continued to meet under the auspices of your committee, with Dr. H. Close Hesseltine serving as chairman of the coordinating committee. Statements of policy covering the proper relationship of the specialists to the hospitals have been drafted and approved by the various Illinois chapters of the specialty groups. The plans, as approved by the ISMS Board of Trustees, include a change in billing procedure for all patients, not just those covered by Medicare. The changeover to direct billing is anticipated by May 1. The support of the entire medical profession is requested.

Other National Legislation

Regional Programs for Heart Disease, Cancer, and Stroke. As initially proposed, H.R. 3140 (S 596) would have established a series of medical complexes throughout the country in which medical care would be rendered directly by the Federal Government in conjunction with research on heart disease, cancer, and stroke. Due to the Illinois representation on the House Interstate and Foreign Commerce Committee in which this legislation was considered, your committee played a key role in the campaign to defeat this bill. Your committee is particularly grateful to Dr. Arthur Goodyear and Dr. William Schowengerdt, ISMS Trustees, for their assistance in this task. As previously indicated, amendments to the bill reduced the scope and size of the program substantially and added the provision that advisory committees, with representation from physicians, must have a direct part in these programs. Also, patients may be treated at these centers only upon referral by local physicians. Following enactment of the bill as Public Law 89-239, steps were taken to gain physician representation on the advisory committees. A Chicago committee, set up under the chairmanship of Dr. Eric Oldberg, President, Chicago Board of Health, has representation from the Chicago Medical Society. A similar committee at the state level, with representation from ISMS, has been established with Dr. Franklin Yoder, Director, Illinois Department of Public Health, chairman. Regulations governing the program were issued in February.

Hart Bill, S 2568 (Medical Restraint of Trade Act). This bill would place the physician in violation of the antitrust laws if a profit is made on the sale of drugs, eyeglasses, or any device dispensed in conjunction with a medical practice. The legislation is an outgrowth of hearings on eyeglass dispensing before the Senate Subcommittee on Antitrust and Monopoly of the Committee on the Judiciary, held during July and August of 1965, plus earlier hearings on drug dispensing. Senator Philip Hart (D—Michigan), chief sponsor, is chairman of the subcommittee. The bill is being opposed because it is highly discriminatory against physicians and in conflict with practices permitted under medical ethics. In addition to affecting the current practices of dispensing ophthalmologists, this bill would interfere with many physicians in the rural areas who find it necessary to dispense drugs and other devices in conjunction with their practices where no other source is available to the patient. In January your committee recruited a delegation of Illinois physicians who journeyed to Washington to register opposition with Senator Dirksen and other members of the Senate subcommittee. Senator Dirksen has publicly condemned the bill as being highly discriminatory and likely unconstitutional. Public hearings are anticipated during this session of Congress. Your committee will continue to monitor the progress of this bill and render opposition.

Animal Research Control Bills. Antivivisectionist groups have long fought progress in medical research by seeking government control over the use of animals in laboratory studies. The campaign has been intensified during the 89th Congress, and some thirty bills were introduced during the first session. Your committee has taken an active part in assisting the AMA in opposing most of these bills. Your committee has also worked closely with the Illinois Society for Medical Research, a group representing the scientific community engaged in the use of animals in research.

Substantial progress has been made in the voluntary upgrading of animal care facilities, and no evidence has been presented to justify charges of mistreatment in the handling of laboratory animals. Particular opposition is being registered to HR 10049 and other similar bills which would provide for an office of laboratory and animal welfare to set standards and provide for inspection of laboratories. Early in February, your committee arranged for the deans of several medical schools and representatives of the Illinois Society for Medical Research to present their views on this bill to a ranking Illinois member of the House Interstate and Foreign Commerce Committee, the committee which has most of these bills under consideration.

Another group of bills in this series would regulate the sale and use of cats and dogs intended for research and experimentation. Certain abuses in animal procurement are recognized. Many of the problems involving unscrupulous dealers and the stealing of family pets would be eliminated if research institutions could obtain unclaimed animals in public pounds.

The administration seems to be uncertain

about its position on this type of legislation. Latest information would indicate that the administration will draft a bill which may not hamper the research effort. The outcome of this move is being carefully watched.

State Legislation

At the time of the last annual meeting, your committee presented a lengthy supplemental report outlining the important measures proposed in the 74th Illinois General Assembly. The session ended some six weeks later, and the resulting legislation was reported to the membership in the legislative *Journal* page, "Legislative Listening Post," September issue.

Fortunately, we were successful in defeating or amending a number of ill-advised measures which would have imposed unnecessary controls on the practice of medicine or jeopardized the high standards of health care enjoyed by the citizens of Illinois. Despite our best efforts, in the closing days of the session, we were unable to prevent passage of Senate Bill 1254, introuced by Senator Paul Simon (D—Troy), which permits applicants for medical licensure to substitute a loyalty oath for the previous declaration of intent to citizenship. Once again, we vigorously opposed the extension of the cut-off date for a group of unqualified chiropractors to continue to legally practice without meeting the standards required of all other chiropractors. We did succeed in limiting this extension to one year rather than the usual two years. This will place the deadline two months into the 75th General Assembly session in 1967. We anticipate moves for a further extension at that time.

In preparation for the 75th General Assembly, we have established within the Legislative Committee, a number of subcommittees to study areas of anticipated legislation in advance of the session. Various physicians from among the general membership are called upon to serve on these study committees. The subcommittees are ad hoc in nature, and in some instances the membership varies from time to time in order to bring in members who are knowledgeable in the subject under discussion. We hope by this method to be much better prepared when the 75th General Assembly convenes in January of 1967.

In implementing the society's legislative program, it is essential that we be able to call upon the membership for letters and other measures of support at the local level from time to time. Members of the Congress and members of the Illinois General Assembly will respond to the views of their constituents much more readily than they will to an appeal from someone outside their district. In numerous instances, we have had occasion to call upon officers, Legislative Committee members, members of the ISMS House of Delegates, and others at the county medical society level. Your committee wishes to thank all of those who have responded to our appeals throughout the year. Since the tempo of medical legislation at both the federal and the state level is on the increase, we anticipate more of these requests in the coming year. Your committee has received much advice and guidance from members of the Board of Trustees, and many Board members have been called upon individually to work directly on our legislative program. We wish to thank them for this support. Appreciation is also extended to the staff.

V. P. Siegel, *Chairman*

George B. Callahan — C. J. Jannings, III

H. Close Hesseltine — Harold A. Sofield

PUBLIC AFFAIRS COMMITTEE LP-2

In 1965 there were 62 county medical societies who had designated public affairs chairmen, increasing public affairs program participation 22% over the prior year. The Public Affairs Committee met four times during 1965—on January 13, July 31, August 1 and December 18. An additional meeting is planned in March. The objective of the Illinois State Medical Society Public Affairs Committee is to work towards a long range solution of medicine's problems through greater representation and effectiveness in the Public Affairs domain by physicians.

The 1965 public affairs program was designed to motivate, educate and equip county public affairs chairmen to execute four basic programs:

1. *County medical society Public Affairs meeting.* The county program chairman and the public affairs chairman were given packaged motivational and educational programs designed to make members of the county society more aware of the political environment and willing to participate and support those who do participate when action is needed.
2. *Report on the issues in politics.* This is designed to make the county public affairs chairman informed in making him able to speak somewhat authoritatively on issues in politics and to inform the membership on matters of importance. These reports were short oral presentations by the county public affairs chairman or a member of his committee at a regular part of the county medical society meeting. Included in these reports were the status of the state and national

issues and how the legislators voted on key bills and news of major events in politics.

3. *Operation Opinion Leader.* A program for downstate only. This program consisted of a series of "invitation only" luncheons or dinners for a select group of allies of the medical profession. The community was given a chance to see the medical profession's position on various issues and gain a greater awareness and understanding of these positions. The purpose was also to secure allies for future action. The emphasis for those meetings, however, was on discussion of mutual problems of interest rather than strictly on airing of medicine's viewpoint. The Cook County counterpart of Operation Opinion Leader was called *Operation Fireside.* The purposes of Operation Fireside are (1) to provide political information, (2) stimulate thinking about politics, (3) motivating individuals into taking action and, (4) identifying the leaders. This project consisted of open discussion sessions conducted by trained physician discussion leaders, held in physicians' homes. The wives were also included in this program.
4. *Support allied groups which advance medicine's goals in the public affairs area.* The public affairs chairman cooperated with groups who worked to advance the efforts of the organizations to advance medicine's goals. IMPAC and AMPAC, Chamber of Commerce and the Illinois Agricultural Association are examples of such groups.

This 1965 program was introduced through a series of Public Affairs Circuit Rider meetings conducted in all the downstate congressional districts. The emphasis on attendance for the Circuit Rider meetings was not strictly on a numerical basis but rather on a representative basis. These meetings emphasized the "how to do it" aspects of the 1965 program for county public affairs chairmen. A kit was prepared for distribution at these Circuit Rider meetings outlining the 1965 program and giving the county public affairs chairman some material to work with in presenting the program to his county society.

The Washington Public Affairs Conference was attended by 90 ISMS members and wives on February 2, 3 and 4, 1965. The Public Affairs Committee arranged the first day's program which included an up-to-date briefing on medical legislation by the members of the AMA Washington staff; individual visits to the congressmen; and an educational program featuring three Washington newsmen from Illinois newspapers, Congressmen Frank Annunzio (D-Ill.) and Bob Wilson (R-Calif.) and Richard Armstrong, Executive Director of the Effective Citizens Organization, a national public affairs group. The annual ISMS congressional reception and dinner attended by 15 Illinois congressmen, Governor Otto Kerner and Congressman Tim Lee Carter, M.D. from Kentucky was held that evening. On February 3 and 4, the Washington conferees participated in the U.S. Chamber of Commerce fourth annual Association Public Affairs Conference which featured leading national figures discussing matters of importance to business and professional people. Many of the ISMS delegation attended as official representatives of the county societies which sponsored their participation.

The public affairs program of 1965 was designed to be *practical* and implemented without great expense or effort in almost any size county. It revolved around the *political* —not the philosophical. Discussions of socialism or non-participation may be fine as they show an interest in issues, but they do not win elections. IMPAC, the Illinois Medical Political Action Committee and AMPAC, the American Medical Political Action Committee are the mechanisms through which physicians and their allies may participate directly in political action. IMPAC, which was endorsed in 1961 by the ISMS House of Delegates is by law a separate effort supported on a voluntary basis by individual financial participation as distinguished from corporate medical society monies. The 89th Congress which proved so disastrous with its proposals for massive federal spending in the health field demanded a greater sophistication on the part of the physicians and their wives for participation in the political processes.

The Public Affairs Committee has realized that if the voice of medicine is to be heard in the halls where the laws are made, there must be a concern back in the districts where the lawmakers are made.

The *Public Affairs Newsletter* was published quarterly in 1965, a non-election year. The publication contained information about politics and government and was designed to be helpful to the individual physicians participating in public affairs.

Public Affairs meetings were held by several county societies with programs devoted to the political processes. Each county medical society was encouraged to hold one such meeting during the year. These public affairs panels were headed by such notable speakers as Dr. Edward Annis, various congressmen, AMPAC representatives, AMPAC board members and other programs including films and panels of legislators and combination of these were also held.

The Public Affairs Committee coordinates its activities with the Woman's Auxiliary in the various county medical societies as well as the Woman's Auxiliary legislative chairman. Films and handouts encouraging wives of physicians to participate in practical politics have been distributed by the Public Affairs Committee.

The first annual *Public Affairs Workshop* will be held March 26, 1966, at the Sherman House in Chicago. The speakers for the workshop include Dr. Blair Henningsgaard of Astoria, Ore.; F. Clifton White, recognized as one of the most knowledgeable and effective political pros in the business today; Senator W. Russell Arrington, the Republican pro-tem of the Illinois state senate; Senator Thomas A. McGloon, Democratic minority leader of the Illinois state senate; Congressman Leslie Arends, the Republican House of Representatives Whip; Mr. Bill Duval, director of civic affairs for the Borg-Warner Corporation; Mrs. Pat Hutar, former assistant chairman of the Republican national committee; Mrs. Amos Johnson, former Democratic executive committee of Samson county, North Carolina (a physician's wife); Roy Pfautch, president of Civic Services Inc. and the campaign manager for Congressman Tom Curtis and Dr. Hoyt Gardner of Louisville, Ky., an AMPAC board member.

The Public Affairs Committee has tried to make the physician aware that a candidate needs and expects more than monetary assistance to be elected, particularly if the donors' views are to be solicited and respected. Developments in the Congress have awakened many physicians to these facts.

Georges Clemenceau, premier of France during World War I, made a famous statement that "war is too important to leave to the generals." Perhaps it is time that the physician decided that politics is too important to leave to the politicians.

The Public Affairs Committee urges every physician to participate in IMPAC by making a voluntary contribution in conjunction with the regular dues assessment.

Theodore Grevas, *Chairman*

William F. Ashley	John A. Newkirk
Carl P. Birk	John W. Ovitz
Francis E. Bihss	James D. Rogers
Walter C. Bornemeier	Peter Rumore
William W. Boswell	Stanley Ruzich
Hershel Browns	John L. Savage
Donald E. Clark	V. P. Siegel
Edwin L. Falloon	Julius P. Schweitzer
Justin Fleischmann	Paul W. Sunderland
Arthur W. Fleming	Eli Tobias
Glen H. Harrison	Frederick Weiss
W. Robert Maloney	Lorin D. Whittaker

IMPARTIAL MEDICAL TESTIMONY COMMITTEE
LP-3

The Impartial Medical Testimony program in the Illinois Circuit Courts (sponsored by the Illinois State Medical Society in conjunction with Illinois Supreme Court) achieved its greatest rate of growth in 1965. Personal injury case usage of IMT examinations in 1965 exceeded the 1964 case total by 53 per cent. This is shown on the chart on page 431. Basically, two factors account for this sizable increase: first, the repeated use of IMT examinations by judges who previously invoked the Illinois Supreme Court Rule (17-2, ordering IMT examinations); second, the fact that seven Circuit Court judges used IMT examinations for the first time.

The frequency of IMT usage in the U.S. Court, Northern District of Illinois, in 1965 (21 cases) increased about 24 per cent over 1964 (17 cases). All Federal Court judges have ordered IMT examinations.

The medical specialties involved in the IMT examinations in both jurisdictions were orthopedics, 30; neurosurgery, 8; neurology, 4; surgery, 1; psychiatry, 3; urology, 1; radiology, 1; ophthalmology, 1; plastic surgery, 1; internal medicine, 1. Several personal injury cases required the services of more than one IMT specialty.

It is believed that continued growth of the Impartial Medical Testimony program will tend to influence reduction of the backlog of personal injury cases in the Illinois Circuit Courts (Cook County, approximately 48,000) by effecting the prompt, equitable disposition of personal injury litigation. This is evident by the 16 court orders for IMT examinations during January and February 1966. Projecting the two-month usage of 16 for 12 months, the 1966 IMT case volume would approximate 100. This would be a significant gain.

Clinton L. Compere, *Chairman*

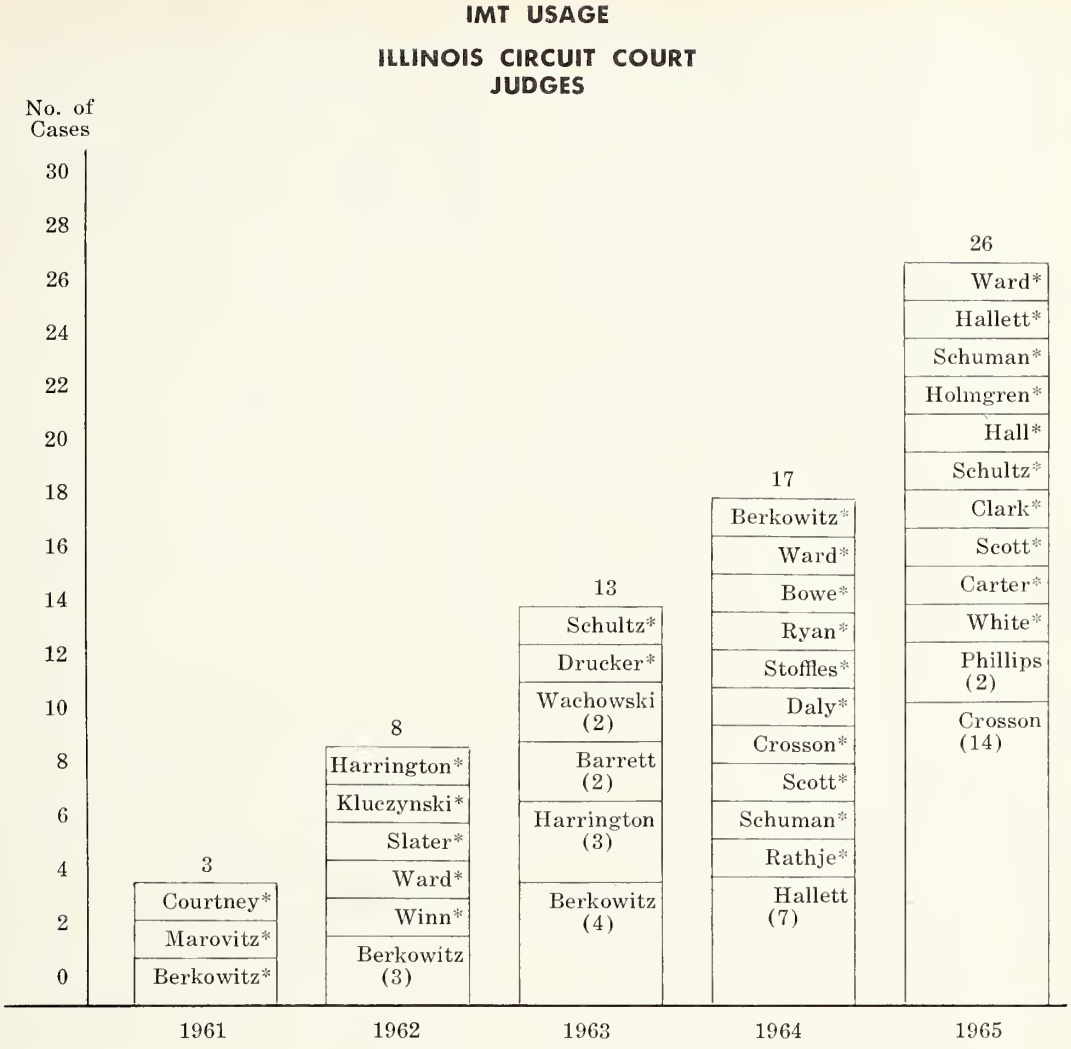
R. Gregory Green	Maurice D. Murfin
Roger A. Harvey	Harry D. Nesmith
Samuel A. Levinson	Vincent C. Sarley
Jerome J. McCullough	Leo P. A. Sweeney

Consultant: Edmund F. Foley

Ex-Officio: Frank J. Jirka, Jr.

MEDICAL-LEGAL COMMITTEE
LP-4

The committee continues its salutary interprofessional liaison with the Medical Cooperation Committee of the Illinois State Bar Association by meeting in joint session to explore, study, discuss, and resolve medical-



Note: * indicates one case

legal problems pertinent to professional interaction of law and medicine.

Interprofessional rapport, harmony, and cooperation, as evidenced by the interrelationships of the members of the committees, have developed to the significant point that mutual understanding of the nature and character of the medical-legal interaction has been achieved. There is presently an awareness of the elements of interprofessional friction and the companion desire to work to resolve the problems for mutual benefit.

Certainly, the major area of friction remaining to be resolved is that of the abuses prevalent in the deposition procedure. The ISMS-IBA committees have thoroughly explored the pertinent facets of this procedure. Actual case histories of deposition situations which posed mutual problems were studied. It was obvious to all participants that conditions of deposition procedure abuse continue to exist in certain types of litigation. It was the consensus that remedial action to correct abuses or excesses of the deposition procedure is warranted.

With the knowledge that interprofessional consideration does not prevail at all levels, the committees are striving to develop a proposal that will make certain changes in the deposition procedure to eliminate abuses encountered by physicians involved in litigation. It is hoped that a concrete proposal will be forthcoming in 1966 to modify the deposition procedure to promote a more effective interprofessional relationship and thereby expedite the adjudicative process.

Both committees are presently involved in rewriting of the interprofessional code that was developed several years ago. It was considered that, in the light of present practices,

revisions and refinements are necessary to improve the efficacy of the code for the medical and legal professions.

The committees have continued careful study and examination of malpractice screening plans that are in operation in several jurisdictions. Intensive study was made of two recently developed plans, one statewide for New Jersey and one countywide for Philadelphia County, Pennsylvania. Both plans, adopted by the respective medical societies and bar associations, include the concept of a screening panel for malpractice claims. The representatives of the IBA and the ISMS committees were planning to visit the New Jersey and Philadelphia societies to determine the effectiveness of the plans. Communication with New Jersey and Philadelphia indicated that a visit at this time would be premature because the plans have not developed to the point that they have sufficient evidence of operation to determine effectiveness. Appropriate follow-up will be made when the various plans have obtained sufficient evidence of operation.

The committee noted the encouraging growth of the Impartial Medical Testimony plan in the Illinois Circuit Courts and the Federal Court, Northern District of Illinois. One area of interprofessional cooperation with respect to Impartial Medical Testimony was the use of the membership mailing list of the Illinois State Bar Association in distributing "Administrative Rules and Procedures for the Impartial Medical Testimony Program" to all of the members of the Illinois State Bar Association. This pamphlet was prepared by the administrative office of the Illinois Courts, printed by the Illinois State Medical Society, and distributed by the Illinois State Bar Association.

The committee realizes the inestimable value of medical-legal interaction and will continue to develop to the utmost the harmonious climate necessary for the resolution of mutual medical-legal problems.

Luis V. Amador, *Chairman*

Clinton L. Compere — John G. Meyer, Jr.
W. W. Dalitsch — George C. Turner

LIAISON COMMITTEE TO DEPARTMENT OF REGISTRATION AND EDUCATION
LP-5

This committee was created at the behest of Sylvester White, former director of the Illinois Department of Registration and Education, to consider mutual problems of physician licensing. Although the present director of the department has not convened the committee, the committee continues to concern itself with problems in this area by contact with the Department of Registration and Education and the Medical Examining Committee and liaison with hospital associations to review the facets and ramifications of the physician licensing situation. The committee, realizing that the subject of physician licensing is one of great significance, holds itself available to offer its advisory services upon request to the director of the Department of Registration and Education.

Jacob E. Reisch, *Chairman*

H. Close Hesseltine — Edward A. Piszczek

COMMITTEE ON QUACKERY
LP-6

The activities of the Committee on Quackery have recently been reassigned to the I.S.M.S. Division of Legislation and Public Affairs. Within this framework, the committee continues to exercise surveillance over this subject area in Illinois. One significant activity undertaken was the initiation of a survey of chiropractors in Illinois. The objective of the survey was to determine the number and identity of unlicensed chiropractors practicing in the state. Conducting the survey, the division forwarded to each component medical society a list of licensed chiropractors in the particular geographic area as reported by the Department of Registration and Education and requested the component society to list the names of other chiropractors in the area. The component societies responded by identifying such individuals. A tabulation is now under way to consolidate the listings from the component medical societies to prepare a master list of chiropractors not reported in the Illinois directory published by the Department of Registration and Education which would be forwarded to the director of the department for further study.

Working in concert with the Division of Investigation of the American Medical Association, the committee studies, investigates, and reports on specific instances of quackery in Illinois. The committee was instrumental in acquiring for the 1965 I.S.M.S. annual meeting the first public display of the AMA exhibit on quackery.

The committee will continue to use the resources at its command to combat the evils of quackery.

Frank H. Fowler, *Chairman*

George F. Lull — Edward A. Piszczek

COMMITTEE ON OCCUPATIONAL HEALTH
LP-7

The Occupational Health Committee continues to encourage, through the resources at

its command, the creation, development and expansion of active occupational health programs for employees in Illinois.

The highlight of the 1965 activity was the sponsorship and presentation of the first occupational health session in conjunction with the ISMS annual meeting. The committee wishes to thank the membership of the society for its support of the occupational health program. The second occupational health session will be presented Monday, May 16, 1966, again in conjunction with the ISMS annual meeting. The 1966 program emphasizes the activities of workmen's compensation programs by highlighting the potential cooperation between medical societies and industrial commissions. Mr. Ralph Gintz, workmen's compensation director, State of Wisconsin, will present the major address. The second segment of the program will be on alcoholism, covering alcoholism and absenteeism, alcoholism and the employee, and alcoholic rehabilitation. The committee feels that this will be a highly significant program for the membership of the Illinois State Medical Society.

Considering its concern with occupational health at the state level, the committee was approached by representatives of the Illinois Section of the American Industrial Hygiene Association with the recommendation that a department of occupational health be established in the Illinois Department of Public Health. The committee met with representatives of the hygiene association on several occasions to study and discuss the proposal. The Occupational Health Committee's recommendation for support of the proposal to establish an occupational health department within the Illinois Department of Public Health will be presented to the Board of Trustees for appropriate action.

Your chairman and staff attended the American Medical Association Congress on Occupational Health, which was held in Indianapolis, Ind., in conjunction with the annual meeting of the Indiana State Medical Association. One facet of this meeting was a session of chairmen of the individual state occupational health committees. Each state occupational health chairman presented a resume of activities within his state, which was particularly meaningful for the other state chairmen. Many programs developed individually have application in other states. Your committee has knowledge of several unique programs operating in New York, California, Wisconsin, and other areas, which are presently under study for application here in Illinois.

In addition to the above, the committee continues to offer specialized occupational health materials required by local medical societies and lay groups, specialized speakers on occupational health or on particular elements of occupational health. Furthermore, the Occupational Health Committee continues liaison with groups similarly concerned at the local and state level.

Edward C. Holmblad, *Chairman*

Charles Asbury — Arthur E. Sulek
Arthur S. J. Petersen — Chester R. Zeiss

COMMITTEE ON LABORATORY EVALUATION
LP-8

Proposed Future Activities: Preparation of a report for publication in the *Illinois Medical Journal* on the current status of laboratory licensure in Illinois. It is contemplated that this report will be prepared following issuance of regulations now in preparation by the Illinois Department of Public Health.

Request for Action: This committee, in accordance with its function "to effect methods of evaluating and maintaining standards of medical laboratories in Illinois" recommends endorsement of resolution of the Illinois Society of Pathologists transmitted to Burtis C. Montgomery, M.D., President, Illinois State Medical Society on June 29, 1965 over the signature of J. Robert Thompson, M.D., Secretary-Treasurer, the Illinois Society of Pathologists. This resolution expresses "the hope of the members of the Illinois Society of Pathologists that the Illinois State Medical Society will attempt to secure modifications of the Illinois Medical Practice Act to define clearly the performance of clinical laboratory procedures as a portion of the practice of medicine."

Review of Activity of the Past Year: 1965-1966 can be characterized as a quiescent period in the activities of this committee. There would appear to have been no activity directed toward the establishment of the authorized committees on laboratory evaluation at the county and district level. Many members of this society continue to refer patients to medical diagnostic laboratories supervised by other than duly qualified physicians.

Subsequent to the 1965 annual meeting of this society, the Illinois General Assembly enacted the Illinois Clinical Laboratory Act and the Illinois Blood Bank Act which were under consideration at the time of our 1965 Annual Meeting. The Clinical Laboratory and Blood Bank Advisory Board provided by these laws has been appointed and its members are drafting recommendations concerned with implementation of the Laboratory and Blood Bank Acts for presentation to the Director

of the Illinois Department of Public Health. Membership of the Advisory Board is as follows: Herbert P. Dexheimer, M.D., and Robert K. Fiersten, B.S., M.S.

James B. Hartney, *Chairman*

Thomas P. deGraffenried — Jack Williams
John Maloney — Hands Willuhn

COMMITTEE ON NARCOTICS AND HAZARDOUS SUBSTANCES
LP-9

The year of 1965 was one of intensive effort for the Narcotics Committee. At the outset, the committee was concerned with the spate of bills on narcotics introduced in the Illinois 74th General Assembly. These bills, designed primarily to impose additional controls on the distribution of narcotic drugs, were generated for the most part by the wanton murder committed by three teen-agers allegedly under the influence of amphetamines and barbiturates. Each bill affecting narcotics was thoroughly studied by the committee, and an appropriate recommendation for support or opposition was relayed to the Legislative Committee of the Illinois State Medical Society. The Narcotics Committee was instrumental in developing a legislative proposal which resulted in the enactment of the Drug Addiction Act. This act created the Narcotic Advisory Council, whose basic function is to promote "development, establishment, coordination, and conduct of unified programs in the field of addiction for education, diagnosis, treatment, aftercare, community referral, rehabilitation, and addiction prevention and control in cooperation with other federal, state, county, municipal, local, and private agencies." Your chairman was appointed by Governor Kerner to serve on the Narcotic Advisory Council.

Considering the present lack of specific programs for the care, treatment, and rehabilitation of narcotic addicts in Illinois in relation to the size of the addict population in Illinois (second only to New York), the committee decided that an appropriate point of departure to obtain knowledge of narcotic addiction and its ramifications would be the presentation of an interdiscipline Conference on Narcotic Addiction. The objective of the conference would be to illuminate the multifaceted problem of narcotic addiction to the point that constructive programs to combat narcotic addiction can be created, developed, and implemented in Illinois. The committee was exceedingly successful in obtaining as conference participants national experts on narcotic addiction who are specifically identified with special facets of the problem.

It should be pointed out that the Conference on Narcotic Addiction is not an end product. It was designed as a mechanism through which specialized task forces would evolve to work on specific problem areas of narcotic addiction applicable to Illinois. Early conference registrations indicate an audience potential of four hundred persons. Cooperating with the Illinois State Medical Society in the presentation of the Conference on Narcotic Addiction are the American Medical Association, the U. S. Bureau of Narcotics, the Chicago Medical Society, the Illinois Department of Mental Health, the Illinois Division of Narcotic Control, the Chicago Department of Mental Health, the Illinois Pharmaceutical Association, the Council for the Understanding and Rehabilitation of Addicts, and Saint Leonard's House. Financial grants in support of the conference were received from the American Medical Association and from the Smith Kline & French Laboratories of Philadelphia, Pennsylvania.

The committee has established effective working relationships with the above cooperating agencies who are concerned with the problems of narcotic addiction. It is evident that the Illinois State Medical Society, through its Committee on Narcotics, has demonstrated a high degree of leadership by bringing together the various professional, civic, municipal, and state organizations involved in combating narcotic addiction.

The committee wishes to thank the Board of Trustees for its enthusiastic support of the committee projects.

The committee shall continue to pursue with the resources at its command the establishment of effective programs for the care, treatment, and rehabilitation of narcotic addicts.

A supplemental report on the Conference on Narcotic Addiction will be prepared.

Joseph H. Skom, *Chairman*

Earl H. Blair — Jordan M. Scher
William U. McReynolds — Ross Schlich
R. K. Richards — George S. Schwerin
David M. Slight



MISCELLANEOUS BUSINESS

LIAISON COMMITTEE TO THE PHARMACEUTICAL ASSOCIATION MB-1

The Liaison Committee to the Pharmaceutical Association met formally on November 20, 1965, to consider the final changes in the Code of Interprofessional Relations for Physicians and Pharmacists. This has been the main activity of the committee for the year. A final report on this will be presented to the Board of Trustees at its March meeting. Should the Board agree on the provisions of the Code, it will then be reproduced and distributed to the members of the House of Delegates for appropriate action.

George B. Callahan, *Chairman*

George F. Lull Edward A. Piszczek
Vincent Sarley

LIAISON COMMITTEE TO THE ILLINOIS OSTEOPATHIC ASSOCIATION MB-2

The Liaison Committee: Illinois Osteopathic Association has had one formal meeting and has had one visit to a meeting of the Illinois Osteopathic Association clinical meeting for a part of an afternoon session.

At the January meeting of the liaison committee, the current status of osteopathy in the United States was reviewed.

The state medical associations in Colorado, Delaware, Iowa, Kansas, Kentucky, Michigan, Missouri, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, and Tennessee have embarked upon programs to assess the nature of the practice of individual osteopaths. Approximately 66% of all osteopaths are located in these states.

In California, the results of the merger of osteopathy into medicine has taken 2,000 osteopaths out of the 14,656 that were listed in 1961 in the United States, so approximately 12,656 osteopaths remain. Of these, 363 practice in Illinois, a ratio of 3.5 per 100,000 population.

In over 100 of the 3,000 counties in the United States, the number of osteopaths equal or exceeds the number of MD's. Illinois has no such county.

In 15 states with 8,149 osteopaths, voluntary professional associations are not unethical. These states have two-thirds of the total number of osteopaths. In Illinois, professional association is not ethical, except where such association is necessary in government institutions.

During 1964-1965 there were five osteopathic colleges in operation in Chicago, DesMoines, Kansas City, Philadelphia and Kirksville, Mo.

A new osteopathic hospital is being planned in Michigan with hoped-for state support. The senate has given approval, but the House of Representatives in Michigan is at the present time conducting a confidential survey to determine the desirability of a merger between osteopathy and medicine. Apparently House approval will depend upon the result of this survey.

Illinois has several osteopathic hospitals, one in connection with the Chicago College of Osteopathy. Another hospital is contemplated in southwest Cook County, but plans for this are not proceeding rapidly or smoothly.

Most osteopathic hospitals have been built by osteopathic physicians, although in recent years public grants-in-aid, community funds and gifts from industry have supported construction costs. Osteopathic projects totaling $50 million have received federal support under the Hill-Burton Act amounting to more than $15 million.

Of the 330 osteopathic hospitals, 91 are approved by A.O.A. for internship training and 60 for residency training; 445 approved residency programs are offered by these 60 hospitals, one fourth of these in surgery.

At the present time there is no active program of communication between the Illinois Osteopathic Association and the Illinois State Medical Society. However relations are friendly and will probably remain friendly as long as the osteopathic physicians gradually continue to move into the position of the practice of medicine and surgery in all of its branches.

Several years ago a committee appointed pursuant to the action of the Illinois State Medical Society House of Delegates was instructed "to report back to the House of Delegates as to its findings, conclusions and recommendations" with regard to professional relationships between osteopaths and the members of Illinois State Medical Society.

That committee held joint meetings with the osteopathic physicians and reported to the House with recommendations. The recommendations were not approved and the committee was discharged.

The present committee was appointed by the Board of Trustees because the American Medical Association two years ago asked that all state societies have a committee on osteopathic problems so that developments in this field can be carefully and constantly evaluated. These things the present committee has done and the above report is a report of its stewardship.

W. C. Bornemeier, *Chairman*

Allison Burdick Sr. — H. Close Hesseltine
Harlan H. English — George F. Lull
L. P. A. Sweeney

MEDICAL ADVISORY COMMITTEE TO SELECTIVE SERVICE
MB-3

The increased activity in Viet Nam has necessitated the building up of our armed forces and consequently has produced a demand for more doctors. Because of this need and a desire that all members of the Illinois State Medical Society shall receive just consideration, President Montgomery appointed an Advisory Committee to Selective Service.

The function of the Medical Society Committee is to assist the Advisory Committee appointed by the U. S. Government. Both Committees have the same objectives, namely (1) to maintain the medical requirements of the community (2) to retain an adequate teaching force in our medical schools and (3) to supply the demands of our armed forces.

Recently there has been considerable anxiety on the part of the Class 2A registrants upon finding they were suddenly reclassified 1A. There was no need for alarm, insofar as this became the instrument in calling all for pre-induction physical examinations. Only those 31 years of age and under are being called and then only after a thorough check has been made as to their essentiality.

Appeals can be made to the registrant's local board upon receipt of induction notice. This must be done within 10 days.

The National Advisory Committee to Selective Service has formulated a schedule to be used as a guide when considering a registrant's essentiality. Your committee follows this schedule as closely as possible.

Being called from family and practice is certainly not desirable. We must remember, however, that others have gone in our place while we received deferment to study medicine. Then as true Americans it becomes our duty to God and Country to do our part when the time comes.

Carl F. Steinhoff, *Chairman*

Earl H. Blair — Raleigh C. Oldfield
Newton DuPuy — Wm. H. Schowengerdt

ILLINOIS ASSOCIATION OF PROFESSIONS COMMITTEE
MB-4

The Illinois Association of Professions has completed nearly two years of activities. Its directors meet every two or three months, and there are 15 committees of the Association. On November 21, 1965, we completed our second annual meeting, and the minutes have been distributed to the membership of approximately 768.

Mr. Robert L. Richards continues to serve

as the Executive Director on loan by the Board of Trustees of ISMS. The clerical work is being performed in the ISMS headquarters office by a secretary employed by the IAP.

Representatives of this committee are scheduled to attend the first National Congress on Medical Ethics and Professions scheduled for March 5-6, 1966. It is our hope that out of this meeting we may secure additional inspiration, as well as activities which may further enhance the work of the Illinois Association of the Professions.

George B. Callahan, *Chairman*

Charles Allison
Andrew J. Brislen
James D. Majarakis
Eugene M. Narsete
Edward A. Piszczek
Vincent Sarley

Ex-Officio: Michael R. Saxon
Robert L. Richards

Sub-Committee of the Illinois Association of Professions Committee:

LIAISON WITH INTERPROFESSIONAL COUNCIL

The Liaison Committee to the Interprofessional Council, a subcommittee of the Illinois Association of Professions Committee, has been meeting regularly with the Illinois Interprofessional Council, and this year the chairman of the subcommittee was elected the President of the Council, and Dr. Whitsell, the first vice president. Other members—Dr. Majarakis and Dr. Bowness, are active on several committees.

This year the Illinois Interprofessional Council, in order more clearly to indicate that it includes only professions serving health needs of the citizens of Illinois voted to change its name to the Illinois Council on Health Professions.

The recipient of the 1965 Annual Award of the Council to a citizen of Illinois for his contributions to the health and welfare of the people of Illinois was Dr. George F. Lull. The plaque which was awarded at the Annual Meeting in June was accepted by Mrs. Lull for her husband who was recovering from surgery at the time.

Part of the citation reads:

"In recognition of his distinguished military career, his years as secretary and general manager of the American Medical Association, his services as secretary-treasurer and president of the Illinois State Medical Society, his membership in the Interprofessional Council, and in further recognition of his contributions to the health and welfare of the citizens of United States as well as those of foreign nations."

The Interprofessional Council is at the present time negotiating for membership in the Health Careers Council of Illinois. Each of the member organizations is represented in the Careers Council so that associate membership is being sought.

The Legislative Committee of the council has been renamed the Committee on Governmental Affairs and the scope of its interest has been widened to include study of national issues. The committee is expected to consult with similar committees of constituent organizations, to analyze health measures pending in the legislatures, to compromise differences in legislative matters so that the council can support programs which receive unanimous approval of the council, and to promulgate the bills which are endorsed by the council.

An ambitious program of public relations has been proposed and public relations committees of parent organizations are being solicited to assist in the development of long range plans.

Andrew J. Brislen, *Chairman*

Lawrence J. Bowness
Walter J. Reedy
David Whitsell
James D. Majarakis





PUBLICATIONS AND SCIENTIFIC SERVICES

EDITORIAL BOARD
PS-1

The *Journal* of the Illinois State Medical Society has undergone many changes in style, format and nature of scientific articles. It is the judgment of the Editorial Board that the *Illinois Medical Journal* is one of the outstanding state society publications in the United States.

Meetings of the Editorial Board with the Editor Dr. Theodore Van Dellen and Mr. Albert Boeck and his staff were held. We discussed the various articles received for publication, those accepted for the *Journal*, reasons for rejecting some articles and the reason for delay in publication of backlog articles.

The *Illinois Medical Journal* publishes scientific articles, editorials, other items including the state society organizational discussions and these cover various areas of interest. Dr. Theodore Van Dellen, the editor of the *Journal*, has the authority to screen all manuscripts received and those accepted for publication will appear in the *Journal* at such time as the editor, in his judgment, determines the importance of the articles for the readers of the *Journal*.

It is the opinion of the Editorial Board that progress is being made. The hurdles and problems of obtaining important scientific articles, and space available for publication in the *Journal* are gradually being resolved by the Editorial Board and the Journal Committee.

Samuel A. Levinson, *Chairman*

Frederick H. Falls	Charles Mrazek
Edwin F. Hirsch	Clarence J. Mueller
James H. Hutton	Jacob E. Reisch
Julius M. Kowalski	E. Clinton Texter, Jr.
Harvey Kravitz	Arkell M. Vaughn
Francis L. Lederer	Edward F. Webb

JOURNAL COMMITTEE
PS-2

Though the *Illinois Medical Journal* has shown consistent improvement during the past four or five years, the Journal Committee has been aware for quite a period of time—and especially during the past year—of the comments of some Illinois State Medical Society members and their criticisms of the *Journal*. These opinions can be summarized in two broad categories: first, the dislike of the scientific and general informational content and second, the monotone-like and somewhat staid method of the presentation of this material.

While these factors are more or less common

to many state medical journals and the realization that a *state* medical publication must have a different format than other medical magazines, the Journal Committee is of the belief that neither of these matters is incorrectable for a journal which represents medicine in a state which is fourth among all others and the scientific material available in it. The committee has been studying ways of improvement of the *Journal* and some of its work is already apparent. The second problem was evaluated first and, after considerable planning and consultation with the printer, changes were instituted in the March issue.

The "new look" in the IMJ to date encompasses a change to a more modern type style, a narrower and more readable column width, new page styling with more attractive title designs and several new section logotypes. As time goes on through the year, other changes will be gradually incorporated so as to provide attractiveness and uniformity with the intent to give the *Journal* a character and individuality readily recognized.

The first category—the scientific content—is currently being thoroughly and methodically studied. Later this year, after more evaluations have been made, the committee will make detailed and specific recommendations to the Editor concerning the quality, the kind and the type of scientific material IMJ should contain. In the development of this policy, the comments and desires of the Society members—the prime readers of the *Journal*—will be given first consideration.

In the production of the *Journal* during the year, close attention to operating economies with emphasis on keeping expenses within the budget was the rule and the practice followed by Mr. Albert Boeck and his staff.

In the 1965 report of this committee, the plan for the year was to save approximately $4,000 to help reduce an anticipated general budget deficiency of the society. The results were better than anticipated — *Journal* expenses were reduced from $107,720 in 1964 to $100,814 in 1965, representing a gross savings of nearly $7,000 to the society over the previous year. While this was both desirable and essential, it did curtail some projected changes and new features. In addition, the committee wishes to note that expenditures were considerably lower than any we can recall in recent years.

Advertising income was reported at $75,951 in the preliminary financial statement, and is not far off the projected figure of $80,000 in the revised financial budget that was adopted in June of 1965. Current situations make it impossible to accurately anticipate the amount of advertising obtainable.

Two new additional publications in this division have helped budget matters. The "Pulse," which appeared as a separate publication in the middle months of 1965, is sponsored under a grant from Roche Laboratories Division of Hoffmann-LaRoche, Inc. In January of this year, another publication was added under the title "What Goes on in Illinois," listing the medical meetings in the state. This is sponsored by a grant from Lederle Laboratories Division of American Cyanamid Company. Both are serving the membership in their own capacities, are self-supporting and are adding revenue to the general fund.

It is appropriate to note here—and Dr. Van Dellen will refer to this briefly in his report—that in a study of publications of similar size and circulation in the medical field, the *Illinois Medical Journal* is doing an outstanding job in holding publishing expenses to a minimum while maintaining excellent standards as a state medical journal. A study in 1964 by J. K. Lasser and Associates covered 51 member publications of the Association of Medical and Allied Publications.

When compared with journals of similar advertising revenue, IMJ total revenue was above average; advertising selling costs were considerably below average ($23.50 per page IMJ to $36.00 survey); the relation of selling costs to revenue was low (13.9% IMJ to 19.9% survey). Relationship of editorial costs to total revenue was a bit higher than the survey average (16.2% IMJ to 13.5% survey), but well below the survey high of 32%. Mechanical costs of IMJ ($4.12 per 1000 pages) were comfortably low in the survey range of $3.42 to $6.31.

More additional sources of publishing income are being explored by the Publications Division in an effort to lighten the pressure on the *Journal* budget. In keeping with the continued emphasis on economy, the proposed *Journal* budget for 1966 is set at $103,000. However, some increases are anticipated in printing and paper costs that are impossible to determine early in the year.

Advertising income for 1966 is expected to reach $80,000 net, and we are hopeful this may be improved as the year progresses. Income is principally derived from pharmaceutical advertising and these firms have been having their problems under new government regulations and restrictions, as you know.

Paul deHaen, a consultant to the pharmaceutical industry and publisher of "New Products Parade of 1965," points out that:

All categories of new products showed a decline in '65 with the exception of new single chemical entities which increased from 17 in 1964 to 23 in 1965. Only 14 of these were

developed by manufacturer's own research departments in the U.S.

The total number of new drug products marketed nationally was 65 in 1965, compared with 82 in 1964 and 126 in 1956. There are some indications, he says, of an increase in new products and chemical entities, but the increase is not expected to be significant nor does it necessarily portent any rosy visions of the future.

The committee wishes again this year to acknowledge the sincere interest in the IMJ and other ISMS publications of Mr. Albert Boeck and his staff, Mr. John Kinney, Miss Claudette Ruffino and Miss Maureen McCarthy. Their desire and capability to make all ISMS publications second to none is to be highly commended. We also wish to thank them for the "odd hours" and "off time" they have willingly spent with the committee in meetings and in planning.

As pointed out previously, the Journal Committee is of the opinion that the *Illinois Medical Journal* can be developed into the finest of all state medical journals and an outstanding medical publication, and the committee's aims and work are dedicated to this result.

Jacob E. Reisch, *Chairman*

J. Ernest Breed — Newton DuPuy
Frank J. Jirka — Darrell H. Trumpe

EDITOR—ILLINOIS MEDICAL JOURNAL
PS-3

During the past year organized medicine was besieged with new government regulations including Public Law No. 89-97 (Medicare). Many of the ensuing principles and policies were brought to the attention of our membership via other Illinois Medical Society publications. As a result, we were able to devote the usual amount of space to clinical articles, including progress reports on various aspects of medicine.

In the past year we published 30 editorials, 11 case histories, 44 book reviews, 26 excerpts from other journals and 76 clinical articles. We also included a monthly report from the president, Dr. Leon Love's View Box, abstracts of Board actions, reports from the Medical Assistants Association, new products, meeting memos and Dr. SIMS in Action. We also acquired the services of Miss Claudette Ruffino, an experienced journalist, as assistant to the editor. In addition, we have subscribed to Mr. Paul de Haen's monthly listing of New Pharmaceutical Specialties to help keep our membership up-to-date in this field. The first in the series of listings appeared in March issue, and the listings will continue as a regular feature for the balance of the year. Mr. de Haen is a consultant to the pharmaceutical industry, author and publisher, with offices in New York City.

A cost analysis of the Illinois Medical Journal for 1964 uncovered many interesting facts. This study covered 51 member publications of the Association of Medical and Allied Publications that were compared by categories of circulation and income so that no individual journal could be identified. More details on the study are included in the Annual Report of the Journal Committee.

Mr. Albert Boeck used the same techniques to compute the cost figures of IMJ as compared to the other journals in the study. He came to the following conclusions:

When compared with journals of similar advertising revenues, IMJ total revenue was above average, but the average income per ad page was lower. IMJ ad selling costs were considerably below average and relationship of selling costs to revenue was low.

The number of text pages for IMJ (873) was very low compared to the survey average of 1,430. The editorial cost per page ($19.85 IMJ) was slightly higher than the survey average ($15.00), but was low in the range of $7.00 to $63.00. The relationship of our editorial costs to total revenue is a little higher than the survey average (16.2% IMJ to 13.5% survey) but well below the survey high of 32%. The mechanical costs of the Journal ($4.12 per 1,000 pages) were low in the survey range of $3.42 to $6.31.

T. R. Van Dellen, *Editor*

COMMITTEE ON SCIENTIFIC ASSEMBLY
PS-4

The Committee met on September 15, with the section chairmen to work out the program for the 1966 convention.

After a review of the 1965 convention, the Section on Pathology decided it preferred its own session this year and the Section on Dermatology requested Wednesday morning for 1966. These changes were approved.

The chairman reported that Dr. Montgomery had requested that the annual banquet be dropped this year and a Gas Light party replace it. This suggestion was approved, forwarded to the Board of Trustees and subsequently adopted.

There was general agreement that there should be an over-all theme for the scientific portion of the meeting and "Early Diagnosis" was accepted.

Section chairmen were briefed on the procedures for their meetings and urged to complete them by November 1. The need for early completion of programs has been a

pressing matter for several years but no method of achieving this has been successful. This still remains the single most important problem concerning the convention and warrants the highest priority for 1967.

The selling of technical exhibits is becoming increasingly difficult because of several factors, one of which is the unavailability of a program at the time the prospectus is mailed. Physician attendance at and interest in exhibits has been satisfactory but improvement would stimulate exhibit sales.

For the future, we would question the necessity for a section on Ob-Gyn, since the Illinois Ob-Gyn Society always holds it annual meeting for one day of the ISMS convention. This means that there are two scientific programs in this specialty, occupying one and one-half days. If the Illinois Ob-Gyn Society is to continue meeting with us, perhaps the section is unnecessary. Although a number of other state specialty groups meet at this time, none of them meets in addition to the section.

Robert T. Fox, *Chairman*

Richard A. DeWall	Robert G. Page
R. R. Fahringer	Gordon L. Snider
Charles P. McCartney	J. Robert Thompson
Harold P. McGinnes	Donald L. Unger

Ex-Officio: William M. Lees

Auxiliary: Mrs. Robert E. Field

COMMITTEE TO STUDY THE CONVENTION
PS-5

The 1965 House of Delegates approved a reference committee report which recommended that the Committee to Study the Convention investigate the possibility of merging the CMS Clinical Conference and the ISMS Convention.

To implement this recommendation, CMS appointed a committee to meet with a subcommittee of the ISMS Committee to Study the Convention, and a joint meeting was held on February 2, 1966.

After each member of the two committees was given an opportunity to speak to the point it became apparent that the majority agreed that the idea of combining the two meetings was good in principle. It would eliminate one of two strong, competing sessions and result in a larger session. Under the present system of two meetings, they compete for attendance, exhibits and program material.

Discussion served to frame up a general schedule which would have ISMS drop its scientific programs and exhibits and schedule only its House of Delegates and Board of Trustees meetings at the time of the CMS Clinical Conference. This, however, presents several problems:

1. The ISMS House of Delegates would have to be scheduled to avoid conflict with the scientific sessions. This might be resolved by having the House meet on Sunday, one night during the session, and perhaps the day following the scientific session.
2. Is it possible to provide for the needs of the specialty groups under the present CMS format? This seems to be the major point to be settled. It was suggested that if the specialties were represented in the scientific schedule, as they now are, they might settle for a luncheon and business meeting.

Each group agreed to consult with its respective Board of Trustees as to the advisability of pursuing the subject further. It was indicated that, should the boards wish it, a draft would be prepared by the two staffs, of a combined meeting with schedule and budget.

George F. Lull, *Chairman*

E. Chester Bone	H. Marchmont-Robinson
Edwin S. Hamilton	Norman E. Powers

Ex-Officio: William M. Lees
Caesar Portes

COMMITTEE ON SCIENTIFIC EXHIBITS
PS-6

At the 1965 annual convention, the Committee on Scientific Exhibits selected 31 exhibits to be shown. The exhibits were well attended, and the exhibitors voiced no complaints regarding facilities, equipment, etc. Winners of Awards were as follows:

FOR ORIGINAL WORK

GOLD "Aminocaproic Acid: Investigations from a University Medical School"
C. Walton Lillehei, William Krivit, J. F. Perry, W. W. Spink, L. P. Sterns and Henry Gans

SILVER "Physiochemical Rationale in the Treatment of Shock"
William Schumer and Khushroo Patel

BRONZE "Cancer Chemotherapy by Intra-Arterial Infusion: A Pilot Program"
A. Richard Grossman and Stuart J. F. Landa

"Anterior Lumbar Fusion"
A. C. Connors, J. A. Rooney and J. P. Carroll

"The Use of An Oral Enzyme Activator in Trauma"
G. Kenneth Lewis and A. Richard Grossman

FOR EXCEPTIONAL EDUCATIONAL VALUE

GOLD "Practical Photoscanning"
Noel F. Strasser, George Krawzoff, H. A. Lerner and John H. Gilmore

SILVER "Malignant Tumors Complicating Pregnancy"
Frederick H. Falls and Charlotte S. Holt

BRONZE "Pulmonary Disease Caused by Photochromogenic Mycobacteria"
The Suburban Cook County Tuberculosis Sanitarium District, Hinsdale

"The Drug Therapy of Hypertension: Its Management and Complications"
Seymour Diamond, Edwin Feldman, and Irvin Belgrade

"Causes and Therapy of Edema: Effect of a New Diuretic"
Frederick Steigmann and Robert Griffin

Twenty-one scientific motion pictures were shown continuously throughout the meeting. They were also well attended.

Thus far we have received 25 applications for space at this year's meeting, and have inquired about the availability of approximately 15 motion pictures.

Coye C. Mason, *Chairman*

Raymond Firfer
Charles P. McCartney
W. H. Newcomb
Lawrence W. Peterson
Arkell M. Vaughn
Leo M. Zimmerman

COMMITTEE ON CANCER CONTROL
PS-7

Report not available for publication.

COMMITTEE ON CARDIOVASCULAR DISEASES
PS-8

Report not available for publication.

CHILD HEALTH COMMITTEE
PS-9

During the year a number of matters were referred to the committee and covered at its meeting.

A discussion of Operation Head Start revealed that the program operated in different ways and with varying degrees of success in 1965. The common problem seemed to be that of having the examinations done in private physicians' offices. The budgets in most cases were not adequate to cover the exams, immunizations, lab tests and follow-up visits. There also was general agreement that the forms were too comprehensive and complex.

The committee recommended that the Board of Trustees submit the following suggestions to the Office of Economic Opportunity for future Head Start operations:

1. That it be mandatory that a physician be included on each local planning committee.
2. That all medical care and examinations be provided, if feasible, by private physicians in their own offices.
3. That the funds allocated must be realistic in terms of the nature of the examinations required.

This recommendation was approved by the trustees.

A report on the PKU program was submitted by Dr. Mary Zeldes of the Illinois Department of Public Health and the committee registered its approval of the way the program was being implemented.

There was discussion of an editorial in IMJ which the committee felt contained some medical errors and mis-statements. Dr. Kunstadter submitted a letter to IMJ correcting these. The committee recommends that in the future greater scrutiny be made of the editorials published in IMJ where the subject is controversial and where there are legislative and/or legal implications.

Most members of the committee agreed there is a slackening of interest by the public in the immunization of children, especially for polio and measles. The committee voted to request ISMS to intensify its education of the public and profession concerning the continuing need for initial immunization and booster programs. It indicated the educational campaign should also emphasize the vital importance of keeping family health records. This was approved by the trustees.

The question of state support for patients with chronic handicapping diseases, particularly asthma, was referred to Dr. Edward Lis for review. Dr. Lis was asked to submit his recommendations, including potential costs, to the chairman for consideration at the next meeting.

The committee received a letter from the Commission on Children asking support for changes in the Illinois adoption laws. When these changes are specifically drafted, they will be submitted to the committee for consideration and action.

In the area of juvenile delinquency, the committee appointed Dr. Irving Abrams to serve as liaison to the Committee on Youth of the Illinois Academy of Pediatrics. Dr. Edward Stepans, chairman, will be asked to accept Dr. Abrams as a representative of the ISMS Child Health Committee.

Now that ipecac has been removed from the prescription list, the committee voted to request ISMS to conduct a publicity program to get ipecac into homes with instructions for poison control. This was approved by the trustees.

The chairman indicated his desire to combine the various sub-committees dealing with school health matters into a single subcommittee on school health. He appointed the following:

Irving Abrams, M.D., Chairman
Howard R. Hone, M.D.
Fred Long, M.D.
Richard Dukes, M.D.
Norman Welford, M.D.
Eugene Diamond, M.D.
W. W. Fullerton, M.D.
Edward Press, M.D., Consultant

Dr. Nolan reported that he attended the National Conference on Day Care.

Doctors Abrams, Munsey and Fullerton all attended the Conference on Physicians and Schools in Chicago last September.

Dr. Fullerton continues to work with the University of Illinois on the Conference on Athletic Injuries. The next conference, on head and back injuries, will be in August of 1966, and Doctors Fullerton and Diamond will represent ISMS.

Dr. Hone informed the group that he had written a dozen organizations offering to speak to groups on the new school health forms but had received only one invitation (Illinois School Nurses Association). He posed the problem of how to get the forms accepted by schools in the state. It was suggested that a letter be sent to Mr. Ray Page, of the Department of Public Instruction, asking him to help with this.

Dr. Dukes reported that District 54 had requested assistance in forming a School Health Council.

After discussion of the matter and a secret ballot, the Committee voted 12-2 in favor of a motion by Dr. Munsey which said:

The Child Health Committee requests the Board of Trustees to seek revision and liberalization of the Illinois abortion law in the following situations:

1. When the unborn child is likely to be malformed due to medical causes,
2. When rape or incest results in the pregnancy of a female child.

After passing the motion, the committee suggested a copy be sent to Dr. Robert R. Hartman, Chairman of the Maternal Welfare Committee, for information. The trustees referred this to the Legislative Committee.

Dr. Fullerton reported that the Statewide Conference of Physicians and Schools will be in Springfield, December 1, 1966.

Experience with the Physically Abused Child Act revealed one weakness in the act in that only cases involving live children were reportable. Cases where the physician found a dead child, or where the child was dead on arrival at a hospital are coroner's cases and not covered by the act.

As a means of correcting this, especially because of the need to check on the condition of living siblings in the family, the committee asked permission of the trustees to write the coroners and request their cooperation in reporting cases. This permission was granted and a letter was sent to all coroners to this effect.

Ralph Kunstadter, *Chairman*

Irving Abrams	Fred Long
Oliver W. Crawford	J. Keller Mack
Eugene F. Diamond	Franklin A. Munsey
Richard E. Dukes	Kenneth S. Nolan
W. W. Fullerton	Leo G. Perucca
Edmond R. Hess	W. H. Schwingel
Howard R. Hone	Walter G. Steiner
Eduard Jung	Norman T. Welford
Edward F. Lis	Walter M. Whitaker

COMMITTEE ON CONTINUING EDUCATION
PS-10

The year was highlighted by the completion of the second edition of the Scientific Speakers Bureau Roster and the increase in speakers' honorarium to fifty dollars.

Response to the roster was good and the inclusion of the speakers' addresses and phone numbers was a valued innovation. The rosters were mailed during the summer to all county medical society officers and program chairmen.

Because of the budget increase necessitated by the raise in honorarium, Merck Sharp & Dohme generously added $1,000 to its previous grant to carry the program through 1965. On February 9, 1966, J. F. Head, regional manager for MSD, presented a $5,000 check to Dr. Caesar Portes to support the bureau in 1966. The Committee wishes to place on record its sincere gratitude for the generosity of Merck Sharp & Dohme for its continuing interest and grants to this activity.

There was no increase in the number of postgraduate courses presented. Courses were held in Champaign County and Warren County with 13 speakers participating. As part of these programs, 1,100 programs, 1,100 postcards and 550 promotion pieces were printed and mailed.

Eighteen counties utilized the services of the speakers bureau and a total of 79 speakers went out to the following counties: Bond (1 speaker), Bureau (8), Coles-Cumberland

(3), DeKalb (7), Jackson (1), Jefferson-Hamilton (1), Kane (6), Knox (7), LaSalle (9), Livingston (8), Macoupin (2), Montgomery (2), Morgan (2), North Shore Branch—CMS (2), Sangamon (1), Stephenson (6), Vermilion (5) and Whiteside (8). The office mailed 3,626 postcard notices related to these meetings.

All in all, 92 physicians participated in 20 counties, 1,650 programs were printed and distributed, and 4,726 postcard notices were mailed.

The committee still feels that more counties ought to be taking advantage of this service and urges the trustees to promote the Speakers Bureau in their respective districts.

Robert J. Freeark, *Chairman*

Hubert L. Allen	Edwin N. Irons
William R. Barclay	Ralph H. Kunstadter
T. Howard Clarke	Louis R. Limarzi
Richard A. DeWall	Mather Pfeiffenberger
J. L. Gibbs	Joseph H. Skom

Gordon H. Sprague

Ex-Officio: William E. Adams

ENVIRONMENTAL HEALTH COMMITTEE PS-11

FUTURE ACTIVITIES

Protection Against Food-Borne Disease

A major and essential portion of the external environment that becomes a part of the internal environment is the food we eat. Last year the committee discussed the current status of programs for the control of food-borne disorders. At that time the State Department of Public Health had jurisdiction of the Grade-A milk pasteurization program, but other dairy products (butter, cheese, ice cream made from Grade-B sources) and all other foods were under the jurisdiction of the State Department of Agriculture. Since then the responsibility for safeguarding many of these other foods was transferred from the Department of Agriculture to the Department of Public Health.

The Environmental Health Committee plans to explore recommendations in the area of protection of food from contamination (or pollution) with pathogenic micro-organisms or with chemical agents that could cause disease or disability. In this area the committee plans to study the possibility of an increasing role for the practicing physician in reporting and preventing food-borne disorders. In addition the possibility of endorsing legislation to revise and up-date the state's Sanitation Inspection Law for food service and processing establishments will also be studied. At the present time no expenditure of ISMS funds is anticipated for this activity.

Health and Injury Aspects of Misuse of Laser Beams

The Laser, or optical maser, is a device for concentrating light to extremely high intensity beams. The word "Laser" is an acronym derived from the first letters of the words "light amplification by stimulated emission of radiation." According to C. H. Townes, Laser radiation is the result of coherent oscillations at optical or infra-red frequencies by use of stimulated emission from excited atoms or molecules. Apparently when these atoms or molecules are excited by a source of energy and placed between parallel reflecting surfaces a light wave travelling between these surfaces will be amplified during each passage. If the amplification is greater than the loss on reflection, the light wave will build up into a coherent oscillation. If a circular area on one of these reflecting surfaces is partially transparent some of the amplified wave may be drawn off into a circular beam. This circular beam of emitted radiation is usually in the wave length of infra-red light or visible light, but it also may include some radiations in the ultra violet spectrum. It has a high degree of monochromaticity and coherency. Because of this coherency and very small angle of divergence it can be focused into a small spot and adjusted to have a very high intensity. The intensity can be so great that it may produce considerable damage to animate or inanimate material. The radiation may be continuous, modulated, or occur in pulses of fractions of a second. For example, using an emission wave length of 10,600 Angstrom units and light generated by a straight xenon flash tube with an intensity of 50 jouls for one millisecond, Fine, et al* found that a beam about a third of an inch, produced perforations of approximately 1.2 millimeters in diameter in a steel plate 0.25 millimeters thick. This is the same intensity beam he used for experimentally producing thermal currents on the skin and cheek pouch of the hamster.

In later research, Dr. Edmund Klein of Roswell Park Memorial Institute in Buffalo, N. Y., found that Laser irradiation though causing only superficial, external damage when focused on the foreheads of mice could cause extensive and frequently fatal internal damage. In other animal studies Laser radiation of the gastro-intestinal tract either directly or through the intact body wall was followed by perforation, peritonitis, and death. In in-vitro studies the action of fibrinolysin was reduced

(*-S. Fine, E. Klein, R. Scott and R. Seed, Laser Radiation in the Syrian Hamster, Skin II:43, Feb. 1963)

and in animal tissue studies Laser radiation resulted in the formation of "free radicals," i.e. extremely short lived molecular fragments that may be associated with neo-plastic processes. Damage to the human eye from both the visible and the invisible infra-red rays are distinct possibilities particularly if the eyes are not properly protected when working with the Laser beams. Laser beams are becoming more and more frequent not only for medical and surgical work but in industry and research and even in educational institutions. There already have been some industrial accidents involving Lasers and with the use of simplified Laser beams in high school science classes and a lack of the awareness of potential hazards both to the eye and other organs and tissues it is felt that some type of medical precautionary recommendations should be developed.

Accordingly the committee plans to develop a series of precautionary recommendations for handling Laser beams in high schools and universities, in industry and in medicine. No ISMS fiscal expenditures are currently anticipated for the formulation of these recommendations.

ACTIVITY OF THE PAST YEAR

Fire Safety Standards for Wearing Apparel and Other Fabrics

Last year the committee recommended and the state medical society sponsored state legislation to control hazards from excessively flammable wearing apparel and other fabrics. With the assistance of the counsel of the medical society and several members of the medical society the chairmen (and others) testified at hearings of both the House of Representatives and the Senate, and in spite of considerable opposition, both Houses passed the bill. However, it was vetoed by the Governor, primarily on technical grounds of its being unconstitutional as drawn up and presented. An effort is planned in the future to redraft this bill and resubmit it to the 1967 legislative session.

Air Pollution

At the recommendation of the Committee on Environmental Health the state medical society passed a resolution last year urging the Governor of Illinois and the state and local air pollution agencies and political jurisdictions to intensify and expand their efforts in the field of air pollution. On this score substantial progress has been made in the enlargement and intensification of the activities of the State Air Pollution Board.

Rules and regulations regarding the open burning of refuse and garbage were promulgated and adopted. Several sources of air pollution from this source were controlled and a case is currently pending in the courts. Work is progressing on the development of ambient air standards. Bi-state legislation between Illinois and Indiana was passed by the representative bodies of both states and action is anticipated shortly in the United States Senate to ratify this. The state funds for air pollution have been increased from $25,000 a year in the previous biennium to $75,000 in this biennium, but additional funds are still needed for the most effective operation of the Air Pollution Board.

Water Pollution

A resolution was also adopted by the state medical society in opposition to any unnecessary discharge of wastes that will result in the degradation of drinking water supply sources or the impairment of water for bathing and swimming. This resolution was transmitted to officials of the State Sanitary Water Board and of the United States Department of Health, Education, and Welfare and it is felt that this, along with many other factors were of assistance in the progress made and regulations adopted by the water pollution enforcement conference held in Chicago on the subject of the pollution of the southern end of Lake Michigan.

The state medical society also sent a telegram to Senators Muskie and Cooper of the United States Senate opposing removal of responsibility for inter-state water pollution from the United States Public Health Service and urging that respective states be given a voice in the preparation of criteria of water quality. Although a bill removing this responsibility from the U.S.P.H.S. was passed, a significant voice was assigned to the respective states in preparing the criteria of water quality.

Pesticide Control

The Environmental Health Committee had urged that legislation to license and regulate the custom sprayers of insecticides and other pesticides be passed and a bill to this effect was passed during the last legislative session. In addition, a commission to study foods, drugs, cosmetics and pesticides was appointed by the Governor.

Summary

Future activities in the field of the adoption of a uniform modern revised sanitary inspection law for food processing and serving is planned, as is the development of recommended precautions to avoid health hazards from the

improper use of Laser beams in medicine, industry, and education. A review of the activity of the past year particularly in relation to efforts to prevent burns from flammable fabrics, to reduce air pollution and water pollution and to improve pesticide control was discussed.

Edward Press, *Chairman*

Howard C. Burkhead — Fred Long
James B. Hartney — R. J. Maganini
E. C. Holmblad — Clarke W. Mangun, Jr.
Ralph H. Kunstadter — Joseph H. Skom
Franklin D. Yoder

COMMITTEE ON EYE HEALTH
PS-12

The Committee on Eye Health is basically an advisory group established to provide information in its area of competence when the need arises. No new activities are planned for the future. No expenditure of funds is anticipated during the next fiscal year.

During 1965-66 the Committee of Eye Health conferred by telephone and letter; no formal meetings were held. During the session of the Illinois legislature the committee provided information concerning several legislative proposals. The Illinois State Medical Society was unusually effective in indicating the unsoundness of a proposal which sought to establish a Vision Service Act similar to the enabling legislation for the Blue Cross and Blue Shield. Although the Vision Service Act was established by nonmedical practitioners, it proposed to provide ophthalmic medical services. Once physicians were excluded from its provisions the sponsors lost interest in the legislation. A proposal to register opticians was considered.

The committee cooperated in the establishment of a program initiated by the Illinois Department of Public Health to screen the vision of children to detect amblyopia exanopsia. The committee approved the establishment of a survey of eye injuries in collaboration with the Illinois Society for the Prevention of Blindness. Advice was provided to a lay group concerning the establishment of a glaucoma screening committee in a small community.

Frank W. Newell, *Chairman*

Peter C. Kronfeld — Manuel L. Stillerman
Walter Stevenson, Jr. — M. Byron Weisbaum

MATERNAL WELFARE COMMITTEE
PS-13

Your Maternal Welfare Committee has continued to meet at approximately quarterly intervals. Because of the unpredictability of tragic accidents with which your committee is concerned, it is obviously impossible to meet at stated intervals. The procedure, therefore, is somewhat as follows:

Upon notification by the Illinois Department of Public Health Consultant in Maternity, your chairman contacts the Chicago office of the Illinois State Medical Society; and with their cooperation, members and alternates as well as special consultants and other interested persons are notified as to the date of the next meeting. An attempt is made to give three to four weeks' notice, although sometimes it is impossible. In spite of these difficulties with scheduling, attendance at the meetings has been remarkable. With one possible exception, it is rare for a trustee district not to have either its delegate or alternate present. On some occasions both come to the meetings, although it is understood that expenses are reimbursable only to one. Your chairman feels that this is evidence of the teaching value of these sessions.

The first portion of each meeting is devoted to a review of the cases that occur at Cook County Hospital. To this end, Dr. Augusta Webster, Chief of Service, brings her house staff to these meetings. These brilliant young men bring to our sessions a freshness and a knowledge of new and experimental techniques which add a piquancy to our discussions which would otherwise be absent.

Your chairman would be amiss if he did not also mention by name Dr. Szantos, of the Hektoen Institute, who has contributed so significantly to our knowledge by his learned presentation of the pathological features of the Cook County cases. The chairman reports with regret the resignation of Dr. Mila Pierce as hematologic consultant, but hastens to comment most favorably on her replacement, Dr. John Louis, assistant professor of medicine at Loyola University.

At the time this report is being written the entire file of the 1965 cases has not been completed. However, of the 60 some odd cases which have been studied to this point at three meetings, it was our pleasure to have in attendance six concerned physicians; and it is our belief that the discussion and interchange added to our mutual understanding.

Hemorrhage continues to be the leading cause of death. We were somewhat amazed to note that 40% of the fatal hemorrhage cases studied so far occurred in ectopic pregnancies. In 40% of these hemorrhage cases, ruptured uterus was the important factor. Sepsis is our number two killer and we were impressed with the importance of endotoxic shock as a cause of death. It appears that our obstetrical death rate will continue to be in the neighborhood of about 3 per 10,000 live births. While

we do not feel that this figure represents an irreducible minimum, the figure has remained essentially static for a number of years. It is interesting, however, that we still see cases with preventable factors which have been discussed time and time again.

Historically, this society has inveighed against the dangers of criminal abortion and for the need for good prenatal care on several occasions. Since these items of patient responsibility continue to plague us, it seems possible that a new effort should be made to emphasize these areas to today's mothers. In the field of physician education there is still need for wider distribution of the lessons learned from these tragic situations, and your chairman feels a sense of neglected responsibility over his failure to be able to make a more concrete contribution in this matter.

Your committee has been pleased to be called upon as a reference source on several occasions and is currently involved in an attempt to present an intelligent recommendation in the controversial field of abortion and sterilization. Again, as this report is being prepared several months prior to the annual convention, this material should be available in final form through the proper channels in time for consideration at the annual meeting.

In addition to this, several members of your committee have been privileged to serve on the Joint Committee for Perinatal Mortality and are optimistic that this effort will lead to a significant improvement in this important field.

In conclusion, your chairman would express his appreciation to the trustees for the privilege of being allowed to continue to serve on this committee and to the delegates, alternates, consultants and other interested persons who have continued to make this contribution not only to the sum total of medical knowledge, but to the betterment of maternal care in Illinois.

Robert R. Hartman, *Chairman*

V. B. Adams
R. E. Bucher
William W. Curtis
William J. Farley
Melvin Goodman
Harry L. Lewis
John J. McLaughlin
Paul A. Raber
Berry V. Rife
Richard F. Whitlock

COMMITTEE ON MEDICAL EDUCATION PS-14

The Committee, as the nucleus of the Ad Hoc Committee on Special Problems of Medical Education, devoted its meetings this year to the resolutions and problems referred to that Committee. (See annual report of that committee, PS 15.)

In addition, however, the committee, at the instruction of the 1965 House of Delegates, wrote the dean of each of the Illinois Medical schools and requested a statement on the disposition of the AMA-ERF funds granted each. The replies are included below.

In general, all schools reported that these unrestricted funds are used to supplement faculty salaries or to provide for additional faculty positions. All indicated the value of having these funds available to use in this fashion so as to strengthen the teaching staff. This seems to be the best possible use of the money and the members of ISMS should feel confident that their contributions to the medical schools are fulfilling a vital need in medical education.

Following are the letters received in reply to the inquiry:

Dear Mr. Richards:

In this school up to the present time the AMA-ERF contribution has been credited to the general income account of the school. However, it has made it possible for us to add one or two members to the faculty or to provide salary increments for those already on our rolls.

I have consulted the business manager of the university and he sees no problem in allocating the funds against one or more specific positions. Hence, beginning July 1, 1966, the AMA-ERF contribution will be used to defray the salary of at least one faculty member at the assistant or associate professor level in the department of pharmacology. Any amount which remains will be earmarked for the defrayment in whole or in part of the salary of one member of the department of physiology. If there is a remainder, it will be used to provide salary increments for other members of these two departments.

In a previous communication, I commented on the great importance of these funds and expressed a hope that the AMA and its state societies will continue to urge physicians to continue their support of medical education.

John F. Sheehan, M.D.
Vice President for the
Medical Center and Dean,
Stritch School of Medicine

Dear Mr. Richards:

Your letter of December 21 has just been received and I am pleased to give you the information you desire with respect to the generous support we have had from AMA-ERF.

First, I should tell you that these funds are maintained by the university in a separate account and are used solely for purposes which the faculty and administration of the College of Medicine consider important and appropriate. Actually, each expenditure is made only

upon receipt of an application and after review and support by the subcommittee of the Executive Committee of the faculty.

In reviewing the minutes of the committee meetings at which appropriations were approved, I note that since July 1, 1964, 12 appropriations have been made, nine of which have been for the procurement of faculty personnel to assist in the educational programs of the college. For the most part, these have been small or modest salary stipends for junior faculty members of the rank of assistant, instructor, and in a few instances, assistant professors. Stipends have been made available only in those instances where it has not been possible to procure regular budgetary support, prior to a new biennium.

Three appropriations were made for improvements other than salaries for academic personnel. These were to improve the facilities for the educational programs in the departments of pathology and anatomy.

Once again, I should like to express our deep gratitude to the members of the Illinois State Medical Society and others who have made this grant possible. I should like to point out, too, that with the flexibility of this grant, we have been able to institute improvements in our educational program much more rapidly than would be possible if we were dependent solely upon appropriations from general university funds.

Granville A. Bennett, M.D.,
Dean
College of Medicine
University of Illinois

Dear Mr. Richards:

I am very happy to respond to your letter of December 21 concerning the importance and value of the contribution on the part of the physicians of the State of Illinois through the AMA-ERF to Northwestern University Medical School. It is difficult to express to you about how strongly I feel about the importance of unrestricted grants to the Medical School. In fact each year now that there are more funds coming from Washington freedom of budgeting medical school expense becomes more difficult. The greatest pressure in budgeting medical school expense, of course, occurs for faculty salaries. Emergency funds are a necessity to bolster an individual's faculty salary when that individual is being pirated by another institution, and also when new programs are being contemplated at times when the budget already has been set.

Northwestern University Medical School consistently has used its AMA-ERF contribution entirely for personnel as investments in individuals bring the greatest returns in teaching, research and service.

The Medical Society of the State of Illinois in allowing physicians to designate 20% of their state dues to medical education really showed leadership to the entire country. The State Medical Society is definitely to be congratulated. It is now the only fund where we really have freedom of utilization. I might add that the amount of money that Northwestern has received has been, I believe, the highest of all of the five medical schools. Actually I don't know where to turn if funds like these were terminated.

Richard H. Young, M.D.
Dean
Medical School
Northwestern University

Dear Mr. Richards:

This will reply to your letter of February 21 addressed to President Sheinin who is away at the present time and who has requested me to reply. Your letter of December 21 was evidently misplaced during his absence due to illness at that time.

The funds provided by the donation of the Illinois State Medical Society as a component of the AMA-ERF program have been allocated entirely to our general teaching budget and used to provide for salary increases and additional teaching personnel, and does not include expenditures for research programs.

This substantial fund is of great assistance in meeting the rising cost of maintaining and upgrading our teaching program. The school appreciates the generous support of the Illinois State Medical Society in the preparation of future physicians.

Andrew H. Ryan, M.D.
Acting Dean
Chicago Medical School

Dear Dr. Richards:

Please forgive our tardiness in responding to your request of December 21 with regard to the use being made of the AMA-ERF allocation to The University of Chicago School of Medicine.

The 1965 allocation of $22,947.58, representing the 1964 contribution, has again been assigned to support the salaries of faculty members engaged in the instruction of medical students. As Dean Bennett and others have pointed out in the past, these unrestricted funds are extremely valuable in helping us attract and retain the teachers of excellence our school must have to educate highly qualified physicians. On behalf of the University and

the School of Medicine, may I express our warm appreciation to the Illinois State Medical Society and to the physicians who generously support this program for continuing to make this very important addition to our resources each year.

Again, I apologize for not having responded sooner but hope this information may be timely and useful.

Leon O. Jacobson, M.D.
Dean
School of Medicine
University of Chicago

In view of the use of these funds, and the sincere appreciation expressed by the deans, it would seem appropriate, insofar as general budgeting permits, to continue this allocation to AMA-ERF.

Daniel Ruge, *Chairman*

Herschel Browns	Mather Pfeiffenberger
Donald H. Dexter	Clifton L. Reeder

AD HOC COMMITTEE ON SPECIAL PROBLEMS OF MEDICAL EDUCATION PS-15

The 1965 House of Delegates considered resolutions 65M-6, 7, 8, 9, 23, 26, 27, 34, 35 and 37, all dealing with problems of medical education and physician shortages, and referred them to the Committee on Medical Education. It further suggested that the committee invite representatives of the five medical schools to its meetings, and that reports be submitted to each meeting of the Board of Trustees.

At its July, 1965 meeting the Board of Trustees wished to further increase the size of the committee to include more downstate viewpoints. Because the committee is a committee of the House, the board could not do this but instead appointed an Ad Hoc Committee on Special Problems of Medical Education which included all members of the Committee on Medical Education plus the other representatives. The two committees met jointly during the year.

Because of the time required for establishing the ad hoc committee, it was unable to meet before the October Board meeting. It did meet on December 8, to organize and review the resolutions referred to it. This meeting was well attended and there was lengthy discussion of the problems.

It was decided at the first meeting that there should be a sub-committee to deal specifically with means of acquainting students with family practice and another to consider the need for a downstate medical school.

Another meeting was scheduled for February 16, to begin to study the problems individually.

Daniel Ruge, *Chairman*

Ernest C. Bone	Mather Pfeiffenberger
Herschel Browns	Clifton L. Reeder
Donald H. Dexter	A. L. Robinson
Jerry M. Ingalls	Santo L. Ruggero
Charles J. Jannings	Robert Schafer
Kenneth F. Kessel	Howard Schneider
Boyd E. McCracken	Stephen Schubert
Morgan M. Meyer	Carl Weisman

Fred Z. White

Ex-Officio: Frank J. Jirka, Jr.
Philip Thomsen

Morton C. Creditor,
Chicago Medical School

Robert G. Page,
University of Chicago

Edward S. Petersen,
Northwestern University

William B. Rich,
Stritch School of Medicine

Melvin Sabshin,
University of Illinois

COMMITTEE ON MENTAL HEALTH PS-16

(Report of Dr. Visotsky as Director of the Illinois Department of Mental Health will be found as an appendix to the report of the Chairman of the Board of Trustees AO-8.)

With the resignation of Dr. Donald Oken as chairman, the Board of Trustees appointed Dr. John R. Adams as new chairman, effective January 16, 1966. Dr. Oken resigned because he accepted a position in Washington and left the state.

In the brief time between his appointment and the deadline for the annual report, the chairman accepted an invitation to represent ISMS on the Committee on the Formulation of Psychiatric Standards of the State Department of Public Health and was scheduled to attend the first meeting on February 17.

The chairman also received a letter from the Illinois Psychiatric Society inquiring about cooperative sponsorship of a meeting on the postgraduate teaching of psychiatry, scheduled for May 14. This request was forwarded to the Executive Administrator of ISMS because of the inclusion of a request for staff assistance.

John R. Adams, *Chairman*

Walter H. Baer	Harry D. Nesmith
Arthur C. Baker	Harry Philips
Louis D. Boshes	Walter P. Plassman
Irving Frank	Albert F. Rauh
Richard J. Graff	F. L. Sullivan

Consultant: Harold M. Visotsky

Auxiliary: Mrs. August Martinucci

COMMITTEE ON NURSING
PS-17

A statement on Dependent Areas of Nursing Functions, prepared by representatives of the Illinois State Medical Society Committee on Nursing, the Illinois Hospital Association and the Illinois Nurses' Association, was approved in principle by a majority of the members of the Nursing Committee via a conference telephone call on January 10, 1966. The Chairman of the Nursing Committee presented the statement to the Board of Trustees on January 16 and it was approved by official action.

The statement recommends that:

1. There be established in each hospital, institution and health agency, an advisory committee on medical nursing practices composed of representatives from nursing, medicine, and administration.

2. The Advisory Committee would be charged with the following responsibilities—(a) Developing written criteria and policies for determining the role and responsibility of the doctor and of the nurse in performing certain procedures in the care of patients; (b) Devise methods for implementing and communicating decisions reached regarding areas of dependent nursing functions; (c) Review at stated intervals any significant changes and developments in medical and nursing practice.

W. I. Taylor, *Chairman*
T. J. Conley — Henrietta Herbolsheimer
Angelo P. Creticos — H. J. Kolb
Nicholas P. Primiano
Ex-officio: Casper Epsteen
Ted LeBoy
W. C. Scrivner

COMMITTEE ON NUTRITION
PS-18

Highlight of the year for the Nutrition Committee was the annual fall conference, Nutrition in Medicine, conducted October 8, 1965, at the Hotel Faust, Rockford, in cooperation with the Illinois Department of Public Health, the Illinois Nutrition Committee, the Rock River Valley Dietetic Association and the Winnebago County Medical Society.

With the fine cooperation of the participating organizations and the individual efforts of Miss Catherine Vial, of the local dietetic association, and Donald Westbrook, of the Winnebago County Medical Society, the conference was highly successful, attracting about 200 people from all parts of the state.

Excellent publicity for the medical society and the cause of nutrition was obtained through the efforts of the Winnebago County Medical Society and the Public Relations Division of the State Society.

Preliminary plans have been made for conducting a similar conference in Quincy in the fall of 1966.

Also scheduled for the fall of 1966 is an all-day symposium in Chicago to be sponsored jointly with the Chicago Nutrition Association and the Chicago Section of the Institute of Food Technologists.

Paul A. Dailey, *Chairman*
James R. Wilson, *Vice Chairman*
John B. Hall, Jr. — Warner H. Newcomb
W. I. Taylor
Ex-Officio: Paul R. Cannon

COMMITTEE ON PERINATAL MORTALITY
PS-19

The first meeting of the Committee on Perinatal Study was held in October, 1962, in Springfield. The stated purpose was to organize the Perinatal Study Committee and to establish its method of operation. Of prime concern was the significant difference in perinatal mortality in various counties and sections of Illinois and the apparent failure of the medical profession to continue lowering the perinatal mortality rates in Illinois in the past 15 years.

It was felt that probably the best method to obtain information was to develop a pilot study. Therefore, 11 counties across the state were arbitrarily chosen because most had active maternal welfare committees which might well form a nucleus for organizing local joint committees in perinatal study.

Accordingly, on December 6, 1962, a meeting of all interested parties was held. Represented were hospital administrators, county medical society officers, maternal welfare committees, health departments, hospital boards of directors, key nurses and councilors of the Illinois State Medical Society. There would be joint sponsorship by the Illinois State Medical Society, the Illinois Nurses Association, the Illinois Hospital Association and the Illinois Department of Public Health.

A report form had been prepared and was reviewed with the many interested parties at that meeting. After a delay of about four months during which the report form was revised, adapted to IBM computer recording, printed and distributed, the study started in June, 1963.

On a purely voluntary basis reports of perinatal deaths were obtained from most of the hospitals in the participating counties. Periodically during the past two years, the committee met to review the reported deaths and to code the forms as to responsibility for the infants' deaths.

In this period of two years we have received

and coded over 600 reports of infant deaths. While the mass of these deaths were unpreventable, there were areas (medically and geographically) where medical advances were not being implemented. For instance, the effect of administering high doses of demerol and morphine to the mother during the latter period of labor repeatedly resulted in severely narcotized premature infants. Also, there were circumstances where hemolytic disease of the newborn due to Rh incompatibility resulted in death of the infant where no efforts were made at appropriate therapy. In some instances Rh antibody titers were never taken in an attempt to anticipate difficulty at birth.

There were also less obvious instances of questionable medical judgment.

It is our opinion that many of these deficiencies could be corrected by continued education, that is a seminar or workshop in the appropriate areas under the auspices of local medical societies or the Illinois State Medical Society.

It is also our opinion that a study of this nature could benefit our entire state. There are several other probable areas where proper education could improve medical practice. We are concerned about our inability to demonstrate continued decrease in infant mortality and feel a thorough evaluation of maternal and infant care is needed in this country if we are to leave this plateau and continue the increase in life expectancy.

Leo G. Perucca, *Chairman*

William W. Curtis	John H. Rendok
Paul A. Dailey	Simon Y. Saltman
Robert R. Hartman	Eugene L. Slotkowski
Harry L. Lewis	Walter G. Steiner
Donaldson F. Rawlings	John A. Taft, Jr.

Velma Foresman, R.N.

COMMITTEE ON RADIATION PS-20

During this past year, the Committee on Radiation had several discussions regarding the non-compliance of an Illinois practicing physician in regards to the regulations as required by the Radiation Monitoring Act.

As a result of the above discussion, the committee recommended to the Department of Public Health the following:

1) Inspections of the physical plant of operating radiological units in the State of Illinois will be made by appointment.
2) Operations of procedures in the use of the above units will be inspected by short unannounced visits.

The Radiation Committee suggested also that the Department of Public Health inspectors of radiological installations not discuss findings with the employed technicians or the operators. It was the opinion of the committee that this information should best be transmitted to the physician supervisor of the installation by the Director of Public Health or his designee at the state level.

At this time, the chairman of the committee is not cognizant of any difficulty or misunderstandings in the interpretation of the Radiation Monitoring Act as it affects the practicing physicians in the State of Illinois.

The committee will continue to meet on call of the chairman as problems regarding radiation are given to him.

Howard C. Burkhead, *Chairman*

Abram H. Cannon	Fred H. Decker
Stephen L. Casper	Robert W. Donnelly
James A. Crilly	Harvey White

Raymond B. White

Consultant: Robert S. Landauer

Ex-Officio: J. Ernest Breed
Carl B. Clark

COMMITTEE ON TUBERCULOSIS PS-21

The Committee on Tuberculosis should continue in the future to keep the society informed about tuberculosis. The importance of constant vigilance, must be emphasized so that the "Pollyanna" attitude which has developed will not continue.

During the past year the committee has held several meetings and discussed the pertinent questions which have come up in the field of tuberculosis here in Illinois.

Chest x-ray surveys and tuberculin testing have again been reviewed as in the past and emphasized. Good case findings will depend upon tuberculin testing of all persons by all physicians. In this way active infectious tuberculosis can be found and treated.

Drs. Bettag and Hall in DuPage County and Dr. Piszczek in suburban Cook County are using and evaluating the "Hypo Spray" method of testing. This has been pioneered by Dr. Hall in the Department of Public Health.

The facilities and services of the state laboratory in tuberculosis diagnosis were carefully reviewed by Dr. Hall. Physicians should be encouraged to make use of these excellent facilities. The new laboratory law makes it mandatory for pathologists to report positive smears, cultures and tissue section to the private physician. It is then up to the physician to follow through.

Resolutions adopted jointly by the American College of Chest Physicians and the Academy of Pediatrics, pertaining to recommended tuberculin testing procedures, appear here for your information.

American College of Chest Physicians, on the recommendation of its Committee on Tuberculosis, adopted the following resolution:

WHEREAS, Tuberculosis now causes the illness of approximately 20,000,000 people and the death of 3,000,000 people in the world annually, and

WHEREAS, It results in more incapacity and death than the other communicable diseases combined, and

WHEREAS, Eradication of tuberculosis must begin with the prenatal period when the environment into which infants are to be born is made free from communicable cases of tuberculosis, and

WHEREAS, Every effort should be made to maintain this environment during the preschool years, and

WHEREAS, The Committees on Tuberculosis in the schools, colleges and universities throughout America should receive the unqualified support of all physicians and tuberculosis organizations in order to maintain an environment free from communicable cases of tuberculosis not only in the schools and colleges, but also in the homes and communities, and

WHEREAS, A program that all present children be tested with tuberculin, that those not yet infected be protected from infection from tubercle bacilli and that those now infected be treated with well-known methods to prevent them from developing tuberculous complications during childhood and possibly from developing destructive clinical lesions later, would speed up the elimination of tuberculosis and

WHEREAS, All necessary procedures are now available to accomplish this goal,

THEREFORE BE IT RESOLVED, That the American College of Chest Physicians and the American Academy of Pediatrics recognize the importance of this program and urge all of their members to support and take part in these activities, and

BE IT FURTHER RESOLVED, That this Joint Committee recommend and urge the members of the two organizations represented to adopt and vigorously promote a program to guarantee an environment free from tubercle bacilli for our infants and children, and

BE IT FURTHER RESOLVED, That this Joint Committee recommend that our respective organizations urge all other groups of physicians, especially obstetricians, general practitioners and health officers, to join in the nation-wide endeavor to protect children against the hazards of tuberculosis.

The American Academy of Pediatrics approved the following statement subject to final action of the Council of the Academy:

STATEMENT ON TUBERCULIN SKIN TESTING OF CHILDREN

Infection with tuberculosis in children is still a problem. Since early treatment with INH has been found valuable for tuberculin converters, particularly in the very young, it is mandatory that tuberculin testing be carried out early in life. This Committee strongly suggests that routine tuberculin testing be initiated between 6-12 months of age (preferably before measles or smallpox vaccine) and be repeated annually. To this end the following recommendations are made:

1. The Mantoux Test is still the most accurate measure of tuberculin sensitivity. Intermediate P.P.D. (5 T.U.) is the standard test done. The reaction to the Mantoux is read on the second or third day. The diameter of induration should be measured and recorded. Ten mm. or more of induration indicates a positive reaction and 5-9 mm. induration is considered a doubtful test and should be investigated further.
2. For clinical screening a multiple puncture test may be employed (e.g. Tine, Heaf). These tests are read in 72 hours. Any doubtful reactions should be checked by Mantoux testing.

Several members of the Tuberculosis Committee are currently serving on the Governor's Committee, and the Illinois Association of Sanatorium Boards special committee, to study the tuberculosis sanatorium bed situation in Illinois. Reports of these committees will be made available later in the year.

Considerable thought was given to the newspaper story in the Chicago Tribune, December 26, 1965, which attempted to show that recent cases of tuberculosis on the U.S.S Wasp would not have occurred if the navy had vaccinated its men with B.C.G.

A letter was written to the Tribune and to the Research Foundation regarding this publicity. Dr. Turner is presenting a resolution to the House of Delegates re-affirming the official position taken by the Tuberculosis Committee on March 26, 1963, regarding B.C.G.

In view of the continued importance of tuberculosis as a disabling and killing disease this committee feels that it should continue to carry out the responsibilities and purposes set forth by the Board of Trustees.

A letter of condolence was written to Erling H. Lunde, after the death of his wife, Mrs. Laura Lunde, recognizing her tireless endeavors in the health field and particularly in tuberculosis control.

Charles K. Petter, *Chairman*

Otto L. Bettag	Hiram T. Langston
Kenneth G. Bulley	David F. Loewen

Clifton F. Hall — Karl H. Pfuetze
Charles A. Lang — George C. Turner
Ex-Officio: William E. Adams
Edward A. Piszczek
Darrell H. Trumpe

COMMITTEE ON STANDARD VITAL CERTIFICATES PS-22

This committee was appointed to serve in an advisory capacity to the Illinois Department of Public Health in regard to the standardization of U.S.P.H.S. forms for reporting births, fetal deaths and deaths.

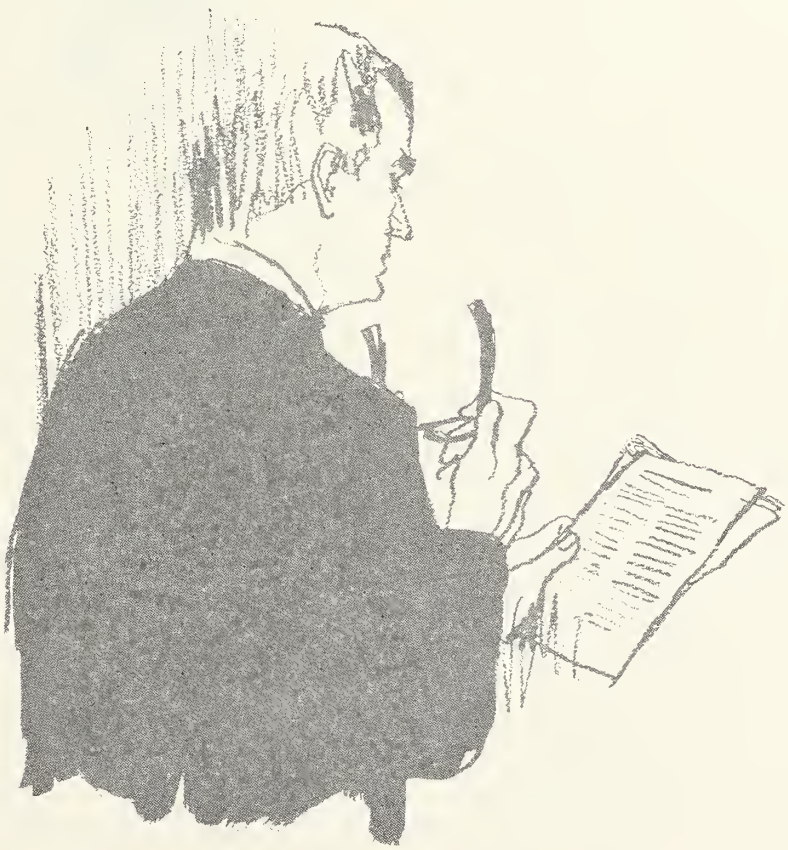
It was called to meet on July 22, 1966, by Dr. Franklin D. Yoder, Director of the Illinois Department of Public Health to review forms proposed by the National Center for Health Statistics, Department of H.E.W.

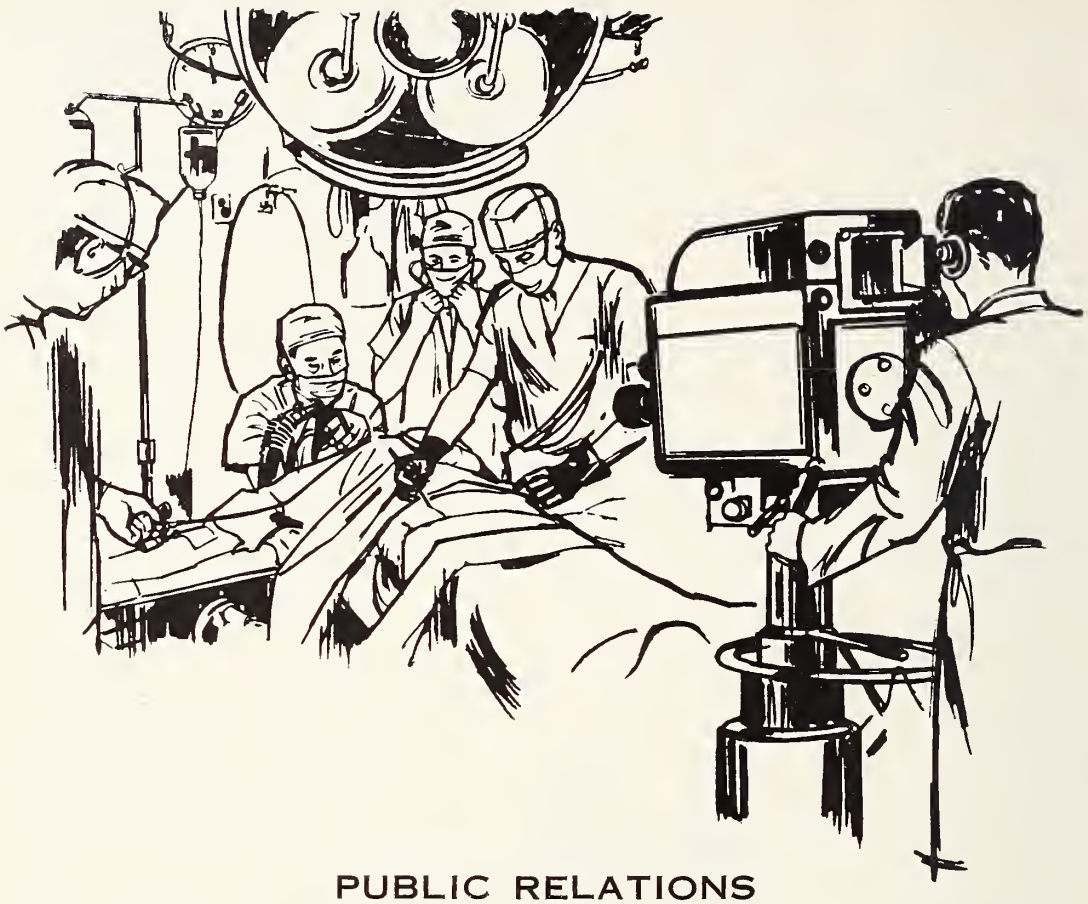
Each certificate form was reviewed carefully and proposed changes discussed individually in terms of their usefulness and compliance with Illinois statutes. Since most changes were related to re-arrangement or compliance with the statutes the committee concurred.

The committee argued against those additions which were unrelated to the purpose of the vital certificate. The committee is advisory only. Mr. Clyde Bridger, of Dr. Yoder's staff, presented the department's view at a meeting of state health department representatives in Washington in November.

Mr. Bridger was to report to the committee after the meeting so it could advise on the final draft of the forms. This meeting had not been scheduled at the time the annual report was due.

H. Close Hesseltine, *Chairman*
Newton DuPuy — Jacob E. Reisch





PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS
PR-1

During the past year, the Public Relations Committee concentrated its efforts in four major areas: development of the society's corporate image; evaluation and expansion of its health education programs; increasing its radio and television services; and development of professional relations with voluntary health agencies.

Newspaper Features

One of the most important aspects of our health education program is the work done by Dr. Charles J. Weigel's Subcommittee on Newspapers.

This subcommittee is responsible for the preparation and distribution of the weekly "Dr. SIMS, Safeguard Your Health" column to the state's 700 daily and weekly newspapers and the unique "Dr. SIMS Talks to Teens" monthly health column to 375 high school publications.

While the subcommittee spent about $1,800 on these public service features, they brought a return of over $207,000 worth of newspaper space. Since contributed newspaper space does not always tell the true story, we set out to determine the effectiveness of the features through a statewide survey of newspaper editors and faculty advisors. Following are the results of the "Safeguard Your Health" survey:

* 305 of Illinois' 700 newspapers publish it regularly or occasionally
* 175 newspapers publish it as a continuing weekly feature
* 84 percent of the editors regard it as excellent or good
* 90 percent regard it as valuable to their readers
* 94 percent want to continue receiving the column in 1966.

Editors' comments were highly complimentary of the series and indicated that the articles were of the desired length and technical level for their readers. Based on replies, we estimate that the readers of "Safeguard Your Health" number at least 3½ million. Actual circulation of newspapers responding to the survey totals more than one million.

A similar survey was conducted among newspaper advisors regarding the "Dr. SIMS Talks to Teens" column and elicited a similar response. Following are the results:

* 92 percent reported the column as extremely popular and valuable as a teaching aid in their school.

* 95 percent wished to continue receiving the column in 1966.

On the basis of these surveys, the Subcommittee on Newspapers is pleased to announce continuation of both features through 1966 and 1967.

New Broadcast Record

For the fourth consecutive year, our radio-TV speakers bureau, films, and recordings set a broadcast record as ISMS compiled over 556 hours of public service broadcast time in 1965 —or 23 full days of airtime.

In terms of dollars and cents, the $9,600 invested in radio-TV production brought the society over $500,000 worth of public service airtime—or about $52 airtime for every dollar invested.

In establishing this record, we placed physicians on almost every interview program in the Chicago area, as well as in Springfield, Decatur and Harrisburg. However the bulk of our broadcast time was compiled throughout the state on programs produced by ISMS itself. They include:

Medical Self Help Training, an accredited 15-week television course originally telecast on Station WTTW, Chicago. Though produced in 1963, the MSHT films continue to be popular. During the past year, they were telecast on Station WTVP in Decatur and WSIL in Harrisburg.

Dr. SIMS TV Health Tips, daily, 20-second health slide messages on preventive medicine. Decatur Station WTVP—which telecast the spots on a pilot basis for six months—liked them so much it aired them five times a day. They are now carried by most of the Illinois stations.

Dr. SIMS Radio Health Tips, daily, 30-second health messages similar to the above. During the past year, these were broadcast over 30,000 times by 56 Illinois stations. ISMS cost: $3,800.

Medical Interview, a weekly, five-minute discussion on timely medical topics, pre-taped for broadcast on 58 radio stations. During the past year, this series has rolled up more than 209 hours.

One-Minute TV spots on rheumatic fever, diabetes and Community Health Week. These spots, distributed to all 23 Illinois TV stations, were telecast 156 times during the year.

Dr. SIMS Children's Show, a weekly five-minute program written and produced by ISMS for insertion in local TV children's shows. Last summer, this segment was featured for 13 consecutive weeks on the Mrs. Carroll Show, WBBM-TV.

Research at Hektoen, a series of weekly, 15-minute radio shows currently broadcast over Station WJJD, Chicago, at 11:45 a.m. Sunday. The 13-week series, which began March 6, was taped on location at Hektoen Institute, Cook County Hospital, and features interviews with staff physicians.

"Home From The Hospital"

Dr. Lee Winkler's Subcommittee on Special Promotions worked with the Hertz Rent-All Company in the publication of a Dr. SIMS manual called "Home From the Hospital."

The booklet—a guide for the care of patients requiring in-home medical care—was published for ISMS as a public service by Hertz Rent-All. The booklet, which cost over $10,000 to publish, explains how to set up a sickroom, administer medicine, tips on nursing care, diets, sanitary measures, etc.

Some 100,000 copies were made available free to the society's 10,500 members for distribution to their patients. Hertz also helped in their distribution to hospitals throughout the state.

Work with Voluntary Health Agencies

Dr. Andrew J. Brislen's Subcommittee on Voluntary Health Agencies was established in June, 1966, to implement the American Medical Association policy of expanding liaison with voluntary groups serving the health needs of our citizens.

The subcommittee was charged with initiating cooperative programs with VHAs, helping them in their educational programs and assisting physicians in their day-to-day association with VHAs. To develop a forum for the interchange of ideas, Dr. Brislen suggested the organization of an Illinois Council of Voluntary Health Agencies.

After five meetings with VHA representatives from throughout the state and nine months of hard work, this was accomplished.

On February 16, 1966, the subcommittee sponsored a luncheon meeting at the Knickerbocker Hotel, marking the formal organization of the new Illinois Council of Voluntary Health Agencies—the first such organization of its kind. While the Constitution and By-laws of the new organization restrict ISMS to an associate membership, its presence in the Council will help ISMS discharge its duties to the agencies and the public.

The Illinois Council of Voluntary Health Agencies — a not-for-profit organization of statewide VHA's—has as its purpose to serve the mutual needs and interests of VHAs in Illinois by fostering:

1. Understanding, communication and cooperation among member organizations

2. High standards of service in the VHA field
3. Liaison with organizations concerned with the health needs of Illinois citizens
4. Public understanding

Charter members, as of February 16, include: Chicago Heart Association; Illinois Association for the Crippled, Inc.; Illinois Chapter, The Arthritis Foundation; Illinois Council for Mentally Retarded Children; Illinois Division of the American Cancer Society; Illinois Epilepsy League; The Illinois Heart Association, Inc.; Illinois Society for the Prevention of Blindness; Illinois State Medical Society; Illinois Tuberculosis Association; National Foundation, March of Dimes; and the United Cerebral Palsy Association of Greater Chicago.

The Council stipulated, however, that six other agencies—which assisted in its formation—would be eligible for charter membership by requesting it before May 15, 1966. They include: Planned Parenthood Association; Muscular Dystrophy Association of America; Illinois Association for Mental Health; Chicago Council on Alcoholism; Chicago Hearing Society; and Diabetes Association of Greater Chicago.

Thus, for the first time in history, representatives of state VHAs joined together in a common effort with the medical profession—thanks to the efforts of the ISMS Subcommittee on Voluntary Health Agencies.

Sex Education Records

Dr. SIMS, corporate symbol of the society, made his appearance in a brand new area last fall—on phonograph records providing sex education for pre-adolescents.

Following the tremendous success of Dr. SIMS Talks to Teens—a unique public service program for Illinois high schools — the PR Committee introduced the new records in cooperation with the Family Information Center, a non-denominational educational foundation of the Catholic Archdiocese.

The records feature a Dr. SIMS message to parents on one side and, on the other side, a 20-minute presentation in which Dr. SIMS explains to the child the facts of sex, conception and birth. One record is designed for boys 11 years and older and another for girls nine years and older.

While the records assure the further prominence of Dr. SIMS, they were produced at no cost to the medical society. They feature the voice of Dr. Max Klinghoffer, a prominent member of the society's radio-TV speakers bureau, who contributed his time and talents.

Outdoor Advertising Awards

In June, 1965, your PR Committee completed its unique, 12-month outdoor advertising campaign on preventive medicine with a billboard message on diabetes detection. The message—carried on some 150 Illinois billboards—was supported by statewide radio and television, newspaper releases, bus and railway advertising, with Upjohn Laboratories underwriting all costs.

The ISMS billboard program proved so successful that three other state medical societies have introduced similar campaigns this year with our assistance.

The $250,000 year-long campaign was underwritten in its entirety by voluntary health agencies and pharmaceutical companies. Bill board space and posting were contributed as a public service by some 33 outdoor advertising companies. The committee expressed its appreciation to these companies by presenting them with attractive plaques at county medical society meetings. The presentations, which received widespread publicity in the local press, were made by various members of the board of trustees and county medical society officials.

Medical Journalism Awards

To stimulate more and better radio-TV-newspaper coverage of medical events—and acknowledge outstanding achievements in medical journalism—the committee conducted its Second Annual Medical Journalism Awards competition.

About 140 entries—more than double that of the previous year—were submitted for consideration, with 17 acclaimed as winners at the March 12 Journalism Awards Dinner, held at the Ambassador Hotel.

Handsome walnut plaques were presented to the following: Chicago Daily News (2), Chicago Sun-Times, Chicago Tribune, Highland Park News, Peacock Newspapers, Mid-County Press, Illinois State Register, Southern Illinoisan, Rockford Register-Republic and Stations WBBM-TV, WMAQ-TV, WBBM, WGN, WIND, WKRS and WTAX.

Judges for the competition were: James Green, TV Guide; Harvey Dean, Mead Johnson Laboratories; Joe Slattery, ABC news commentator; William Lyons, Southern Illinois University; Emmet Curme, Advertising Age; Frank Spencer, United Press International; Joe Dill, Associated Press; and Gerald Healey, Editor and Publisher. Assisting them were Drs. Robert Mendelsohn, Sweeney, Brislen and Weigel.

Community Health Week

Dr. Matthew B. Eisele's Subcommittee on Community Health Week parlayed a $2,500 budget into a $50,000 promotional campaign in the biggest and most meaningful CHW ever staged.

For the first time since its inception in 1962, CHW was not just an ISMS promotion. Voluntary health agencies and commercial groups—such as the Chicago and Illinois Heart Associations, Illinois Bell Telephone and Hertz Rent-All — gave their support to the CHW theme "The Role of the Voluntary Health Agencies in Your Community."

This theme was selected for two reasons: (1) to express our appreciation and support of the voluntary health movement, which has contributed so much to the advancement of medicine; and (2) to foster a working relationship with the various statewide voluntary health agencies.

As in 1964, ISMS enlisted the aid of "name" celebrities to head the campaign as Chicago Cub Star Ernie Banks and Johnny Morris of the Chicago Bears made various radio and TV appearances as honorary co-chairmen.

The 1965 CHW promotion (November 7-13) was highlighted by the following:

Contributions — the Chicago and Illinois Heart Association thought enough of the program to contribute $500 each to the ISMS promotion.

Advertisements — Illinois Bell Telephone paved the way with full-page CHW ads in 20 of Illinois' largest dailies. If ISMS had to pay for these ads, it would have cost over $25,000. Hertz Rent-All also published a supporting advertisement in the Chicago Tribune.

Radio Spots—A record was produced containing five different CHW messages from Ernie Banks and Johnny Morris. The records, distributed to all 120 Illinois stations, were written for broadcast the week prior to and during CHW.

Television Spots—Two TV spots, 20 and 60 seconds in length, were produced and distributed to all 23 Illinois TV stations. They, too, featured Banks and Morris and were used extensively, especially by the Chicago stations.

Medical Interview—a five-minute Medical Interview radio program was produced and broadcast on 56 stations. The program featured Louis deBoer, executive director of the Chicago Heart Association.

Newspaper Releases—A three-part feature series tracing the history and scope of the voluntary health movement was prepared and distributed to all 93 Illinois daily newspapers. A separate article was prepared for weeklies. In addition, ISMS released a suggested editorial and story on the governor's CHW proclamation.

TV Presentation—Additional publicity was obtained when Dr. Caesar Portes, ISMS president-elect, presented plaques of appreciation to Morris and Banks. Film segments of the presentation were telecast by WBBM-TV.

CHW Kits—CHW kits were prepared and distributed to all county medical societies, with a list of suggestions on how to implement CHW on the local level.

Personal Appearances — In addition, Dr. SIMS made a personal appearance at a CHW Health Careers Conference at Oak Park-River Forest High School and a number of physicians made radio-TV appearances in support of CHW.

The theme selected for the 1966 CHW promotion is Health Careers. Dr. Eisele has already pledges of support from the Health Careers Council of Illinois and the Illinois Bell Telephone Company in the promotion.

Dr. SIMS at State Fair

As in the previous year, Dr. SIMS paid a visit to the 1965 State Fair in Springfield to man the ISMS State Fair booth. Dr. SIMS —portrayed by a representative of the PR staff wearing a three foot high plasticized head—once again attracted record-breaking crowds to the ISMS exhibit on Quackery.

Parents and children alike shook hands with the ISMS symbolic emissary in what amounted to the most successful State Fair promotion in ISMS history. He proved an ideal goodwill ambassador as he distributed to youngsters some 10,000 balloons bearing the face and health message of Dr. SIMS. As balloons were being inflated in the exhibit area, waiting parents received more than two tons of health educational pamphlets from volunteers of Sangamon County Women's Auxiliary.

Dr. SIMS proved so popular that Governor Otto Kerner paid him a visit to pose for pictures. In addition, Springfield television stations featured him on two different TV programs during that week.

While we look back on the past year with a sense of accomplishment, it is important to recognize that we have made only a small dent in the public relations problems facing our profession. Much more remains to be done, and the committee is confident that with the continuing support of the House of Delegates and the Board of Trustees, this will be accomplished.

Leo P. A. Sweeney, *Chairman*

Matthew B. Eisele
Andrew J. Brislen
Charles J. Weigel
Lee F. Winkler

PHYSICIANS' PLACEMENT SERVICE PR-1A

During the past year, the Physicians' Placement Service was directly responsible for the placement of 19 physicians, one more than the previous year.

General practitioners were placed in Pon-

tiac (3), Havana (2), Chicago (2), Odell (2), Tuscola, St. Charles, Plano, Witt, DuQuoin and Nashville, while specialists were situated in Rockford, Champaign, Springfield and Macomb.

In addition, ISMS assisted in the placement of 19 other physicians, including 10 general practitioners and nine specialists.

According to Mrs. Jane Swanson—secretary of the Placement Service since its inception in 1945—placement statistics have remained approximately the same during the past five years, a discouraging fact in view of the society's increased efforts on behalf of rural areas.

The problem of rural area placement is not unique to Illinois, however, for medical societies throughout the country report a general decline as a result toward specialization and metropolitan area practice.

During the past year, the Placement Service had a total of 904 physician-applicants on its mailing list, as compared to 886 last year. While 344 still receive our notices of openings, some 560 have been removed because they have either found suitable locations or have neglected to answer our follow-up letters.

Meanwhile, we have publicized 426 opportunities, as compared to 364 the previous year. While 69 have been removed for various reasons, we continue to publish 357. The following is a tabulation of physician-applicants and opportunities available as of February 1, 1966.

SUPPLY AND DEMAND OF APPLICANTS AND OPENINGS AS OF FEBRUARY 1, 1966

Specialties	*Physician Applicants*	*Openings Listed*
General Practice	40*	205**
Anesthesiology	11	2
Dermatology	17	4
Internal Medicine	49	29
Neurology	1	1
Neurological surgery	4	3
Obstetrics-gynecology	33	10
Ophthalmology	13	11
Orthopedic surgery	14	7
Otolaryngology	9	19
Pathology	15	2
Pediatrics	11	27
Psychiatry	8	5
Radiology	15	0
Surgery	53	13
Urology	10	8
Miscellaneous	12	12
	315	357

*does not include student loan recipients
**139 in solo practice—66 in associate practice

Note that we had some 205 openings for general practitioners last year, but only 40 GP applicants. This is especially alarming when you consider that in 1956 ISMS had 180 GP applicants for 100 openings. So while the demand for GP's continues to rise in rural communities, the number of available physicians has fallen sharply.

In tabulating physicians' preferences for states, the American Medical Association notes that 19 percent indicate willingness to locate anywhere depending upon the opportunity available and ability to obtain licensure. But on the basis of applications, the first 10 specific state preferences among physicians were: 1) California, 2) New York, 3) Connecticut, 4) Arizona, 5) Colorado, 6) Washington, 7) New Jersey, 8) Oregon, 9) Pennsylvania and 10) *Illinois.*

Meanwhile the Sears-Roebuck Foundation reports that it assisted 30 communities throughout the United States to obtain resident physicians during the past year. The report points to Viet Nam, specialization and the trend among medical students toward research as being the chief factors in bringing about the lack of general practitioners available to fill the many openings being reported.

During the coming year the secretary intends to place increased emphasis on keeping the recipients of our Student Loan Fund informed as new openings arise, as they are probably our best source of material in the years immediately ahead.

COMMITTEE ON PUBLIC SAFETY PR-2

The primary concern of the Committee on Public Safety for 1965-66 was carrying out educational programs and implementing amendments to "The Coroner's Act"—providing a twelve month's blood alcohol/carbon monoxide study on all traffic fatalities, including pedestrians.

The Coroner's Act amendments were passed by the State Legislature in 1965 as a direct result of the Committee's two years' effort.

The Committee began its educational program in October with mailings to thousands of interested groups, officials, news media, and individuals to inform them of the study due to begin January 1, 1966.

The bill called for testing alcohol and carbon monoxide content of the blood of all traffic fatalities (estimated at 2,400 during the one-year period).

Members of the Committee along with ISMS staff were invited to personal conferences with Governor Otto Kerner and Secretary of State

Paul Powell in Springfield. Committee members also gave testimony before hearing committees of the legislature on this bill and related traffic safety legislation.

The educational program and implementation of the study involved many hours to work out numerous details: laboratory slips, tubes and equipment to be used; cooperative efforts with the Governor's Official Traffic Safety Coordinating Committee and the Illinois Coroner's Association; contacts with physicians, hospitals, technicians and others.

Reception to ISMS publicity on the study was excellent. More than 60 newspapers used stories released by the Public Relations Division; several large metropolitan newspapers published feature stories of their own; six newspapers wrote editorials commending the study; two "ISMS Medical Interview" radio programs were produced on the subject and broadcast on 50 Illinois stations; and Committee members compiled many hours of personal appearances on radio and television in behalf of the project.

In addition to the Blood Alcohol Study, the Committee:

1. Continued support of the Cornell University Accident Crash Injury Research (ACIR) Project by contacting more than 7,000 physicians who were asked to cooperate.

2. Considered proposals dealing with civil aviation safety and legislative needs in this aspect of Public Safety.

3. Considered legislative needs in respect to driver's licensing of discharged mental patients.

4. Issued confidential letters regarding possible defective tires to a major tire company upon receipt of specific complaints to the Committee.

5. Discussed plans for a booklet on First Aid for ambulance drivers and other persons engaged in First Aid.

6. Endorsed an eye injury study initiated by the Committee on Eye Health in conjunction with the Illinois Society for the Prevention of Blindness.

The Committee expresses its gratitude to James R. Slawny and Les Kennon of the Public Relations Division for unusual diligence and extraordinary efforts in assisting this committee throughout the year.

Julius M. Kowalski, *Chairman*

Clarence E. Cawvey — Edwin A. Lee
George H. Irwin — Norman J. Rose
Clifford P. Sullivan

Auxiliary: Mrs. Joseph Shanks

ADVISORY COMMITTEE TO ILLINOIS MEDICAL ASSISTANTS ASSOCIATION
PR-3

The ISMS Advisory Committee to the Illinois Medical Assistants Association is pleased to report that the first full-year program of cooperation between ISMS and IMAA has met excellent success in establishing the potential of IMAA as a service organization.

According to the proposed program — approved by the Board of Trustees last year — IMAA established its official headquarters in our central office at 360 North Michigan Avenue, Chicago, with its records and correspondence on file there.

Through our staff and advisory committee, we have rendered IMAA counseling, professional assistance and part time secretarial help in the implementation of such activities as:

Membership Campaign. In June, we assisted IMAA in launching a statewide membership drive which involved the writing, printing and distribution of an IMAA promotional brochure and letter to the medical assistants of the society's 10,500 members. This promotion resulted in a 23 percent increase in IMAA membership during 1965.

Publicity. Advance and followup news releases were prepared on members attending the IMAA's 1965 and 1966 annual convention held each April. Arrangements were also made for radio and TV coverage of convention highlights. In addition, hometown news releases were prepared on members attending the IMAA's educational symposiums, quarterly council meetings and other special events.

Monthly Newsletter. The Society edits, publishes and distributes a monthly newsletter—the "Executive Memo"—to IMAA members to keep them up-to-date on all association activities. This project is accomplished through the cooperation of IMAA president, Mrs. Shirley Kleinschmidt.

Other ISMS activities on behalf of the association include the printing of officers and committee's annual reports, council meeting minutes, IMAA stationery and special promotion pieces.

IMAA has reimbursed the society for a good substance of such out-of-pocket expenditures as secretarial services, paper, printing and plates used in IMAA projects. Services provided by the society's staff, such as our Public Relations Director—who serves as staff coordinator on all IMAA projects channeled through the society—are available without charge.

The chairman of the IMAA advisory committee feels this program of assistance has greatly enhanced the relationship between the

two organizations, and will continue to do so by sustaining and implementing new projects of assistance.

Maynard I. Shapiro, *Chairman*

Donald E. Dick — William G. McCarthy
Clarence G. Glenn — H. H. Pillinger, Jr.
Thomas R. Harwood — Fred L. Stuttle
Chauncey C. Maher, Jr. — Harold Swanberg

ADVISORY COMMITTEE TO THE HEALTH CAREERS COUNCIL OF ILLINOIS
PR-4

The Advisory Committee to the Health Careers Council of Illinois (HCCI) was established August 2, 1965, by the Board of Trustees, upon the recommendation of Dr. William E. Adams.

It was charged with the responsibility of advising HCCI on careers in medicine, assisting it in the development of new financial resources and keeping the ISMS membership abreast of the supply and demand of health personnel.

From its two committee meetings and various contacts with the HCCI, the committee learned that the critical shortage of health personnel exists not only in the high levels of research, administration and teaching, but across the entire range of health careers.

In Illinois hospitals alone, for instance, there are currently over 6,000 vacancies for positions in allied health occupations. Critical as the problem is today, however, studies project an even worse situation with the demand for nurses, dietitions, medical technicians, medical record librarians, etc., at least doubling by 1975.

Unless we can fill a great portion of these vacancies, through the recruitment programs of HCCI, the quality of medical care in Illinois will dip sharply having a deleterious effect on patient care.

Increasing HCCI recruitment programs is not as simple as it sounds, however, for the Council is in serious financial difficulty. And — unless organizations like ISMS increase their financial support considerably—HCCI could fold, leaving all Illinois health professions without recruitment programs to fill the increasing vacancies.

As leaders of the health team, we cannot afford to let this happen. While it is true that hospitals are the primary employers of these personnel, we, as physicians are heavily dependent upon them to help us carry out our responsibilities to our patients. We are obligated, therefore, to take the lead by providing HCCI with all the financial support possible.

In conclusion, the committee strongly urges the House of Delegates to recommend to the Board of Trustees an increase in financial support to HCCI from $1,000 to $20,000 a year. It is suggested that the funds be obtained by allocating $2.00 from each members' dues beginning January 1, 1967.

Maynard I. Shapiro, *Chairman*

Allison Burdick, Jr. — Edward A. Piszczek
Jack L. Gibbs — Francis W. Young

FIFTY YEAR CLUB COMMITTEE
PR-5

Some 69 physicians were initiated into the ISMS Fifty Year Club in 1965, bringing the organization's membership to 503. Since 69 members passed away during the year, membership remains the same.

Among the new members are 50 physicians of the Chicago Medical Society—most of whom received their certificates and pins at the club's 1965 luncheon meeting—and 19 downstate physicians who were honored at the local level by their county medical societies.

The annual luncheon program held in conjunction with the society's 1965 convention in May, attracted some 149 members, with feature stories and photographs of the event published in newspapers throughout the state, as well as the ISMS "Pulse" newsletter. Principal speaker was Chairman Dr. Morris Fishbein, who discussed "Reminiscences of the Past 50 Years."

This year—in an effort to recapture the "wonderful days" of 1916 when the club's new members began practice—the Fifty Year Club will take its members "down memory lane" with an interesting program of slides, films and skits depicting Chicago Medicine as it was shortly before World War I. The program is scheduled for Tuesday, May 17, in the George Bernard Shaw Room of the Sherman House.

George F. Lull, *Chairman*

Morris Fishbein — G. C. Otrich
Walter H. Theobald

GRIEVANCE COMMITTEE
PR-6

With the exception of some 60 cases still pending—and one settled in court—all of the 529 reported complaints against ISMS physicians during the past year were settled on the local level by County Medical Society committees.

Of the 54 county societies submitting Annual Reports, only 13 found it necessary to process complaints.

Following is a tabulation of the reports, with the Chicago Medical Society considered

apart from the smaller downstate societies which are considered as a group.

Chicago Medical Society	
Number of complaints	438
Cases pending	58
Breakdown of complaints:	
(a) Excessive fees	173
(b) Others	265
Manner of Settlement:	
(a) Through satisfactory explanation	137
(b) Through reduction in fees	36
(c) Through other means	51
(d) Cases pending	145
Physicians upheld	145
Physicians censured or referred to Ethical Relations Committee	11
Downstate County Societies	
Number of Counties reporting	53
Number of complaints registered	91
Breakdown of complaints:	
(a) Excessive fees	44
(b) Service	16
(c) Others	31
Manner of Settlement:	
(a) Through satisfactory explanation	77
(b) Through other means	1
(c) Through reduction in fees	8
(d) Pending	2
Physicians censured or referred to Ethical Relations Committee	6

An analysis of the survey reveals that the total number of complaints increased from 458 last year to 529 in 1965.

Complaints regarding physicians' fees, rose from 179 last year to 217 in 1965. This figure represents 33% of the total complaints for 1965—a percentage drop of 9% from last year.

Arkell M. Vaughn, *Chairman*
A. K. Baldwin — Frank Fowler
Allison L. Burdick, Jr. — Victor V. Rockey
William H. Walton

DISASTER MEDICAL CARE COMMITTEE PR-7

During 1965-66, the Disaster Medical Care Committee concentrated its work in five major areas:

Publication of a Disaster Manual for Hospitals; promotion of the Medical Self Help Training program; establishment of a Packaged Disaster Hospital in Springfield; promotion of fallout shelters under highways; and speaking engagements on radio, television and before hospital groups.

Disaster Manual

Highlight of the year was the publication of a 72-page Disaster Manual for Hospitals, designed to provide a guide for hospitals wishing to establish or modify an emergency plan. The manual—a revised, updated edition of the committee's 1962 publication—was partially underwritten by the U. S. Department of Health, Education and Welfare.

It includes guides for handling local disasters—as well as nuclear catastrophes—by describing duties and assignments of hospital personnel, equipment and space allotments. About 1,000 copies have been distributed to Illinois hospitals and civil defense groups. Another 500 are being made available free upon request.

Medical Self Help Training

The committee stepped up its promotion of Medical Self Help Training in a variety of ways. The most dramatic and effective promotion was the telecasting of its 15-part film series on Station WSIL in Harrisburg and WTVP in Decatur.

While the television series may not be as complete as the live, classroom presentations, we are convinced that it represents the most practical way of reaching the largest number of people. With that in mind, we are exploring the possibilities of telecasting the series on a Carbondale station in 1966.

In an effort to stimulate further interest, MSHT racks and brochures were placed in emergency rooms of five Illinois hospitals. The promotion, designed as a pilot program, proved highly successful in the distribution of MSHT brochures, but considerable difficulty was encountered when county and municipal political bodies were unable to provide the MSHT programs publicized in the brochures.

Therefore, until there is further cooperation from the various governmental agencies, we will limit distribution of promotional brochures to communities where the course is definitely offered.

The committee also worked with the regional office of the U. S. Public Health Service in the distribution of a triangular window decal to persons who have completed the MSHT course. We are also pleased to report that the Illinois Pharmaceutical Association is assisting in the promotion by placing MSHT brochures and informational kits in drug stores throughout the state.

Packaged Disaster Hospital

Thanks to the efforts of the regional office of the U. S. Public Health Service, the Illinois Public Health Service and Dr. Jack Baldwin—one of our committee members—a Packaged Disaster Hospital training program is being established in a Springfield school this spring.

The program—designed to train hospital and civil defense personnel in setting up and utilizing the PDH unit—will be supervised by Dr. Baldwin and financed with the assistance of the U. S. and Illinois Departments of Public Health. (The PDH unit was formerly known as the Civil Defense Emergency Hospital).

In addition to the new PDH in Springfield, Memorial Hospital of DuPage County in Elmhurst has added a wing which includes an underground section specifically designed for storage of a PDH. The regional office of the U. S. Public Health Service is expected to move a 1962 PDH into that area and furnish Memorial Hospital with the major components from an early model PDH to enable Memorial Hospital to set up a PDH training program.

Upon completion of the Springfield and Elmhurst units, the committee plans to establish a third training unit in the Southern part of the state, possibly in Carbondale. PDH programs are being carried out jointly by the ISMS Disaster Medical Care Committee, the Illinois Department of Public Health, the Illinois Civil Defense Agency and the regional office of the U. S. Public Health Service.

Shelters Under Highways

The committee continued to advocate the construction of fallout shelters under elevated highways. Committee representatives met twice with the Illinois Association of Professions and were fortunate in obtaining their support in promoting the plan.

Relative to this subject, the Association for the Advancement of Science devoted a large portion of its winter meeting in Berkeley, California to the idea of constructing massive tunnels under all major cities as a definitive shelter program. Upon reading this report, we corresponded with the men who proposed this program—Drs. Eugene Wigner and J. C. Breese of the Atomic Energy Commission—and offered as a more practical solution our own idea of shelters under elevated highways. We had received very encouraging correspondence from them and, from all appearances, the committee will have their support in promoting such a program.

Speaking Engagements

One of the most time-consuming, yet effective, jobs of the committee was its 21 personal appearances before hospital staffs, civil defense groups, paramedical groups, radio and television. Following is a list of committee presentations:

American Hospital Association; American Osteopathic Association, Rockford; Mary Thompson Hospital, Chicago; Registered Nurses of Northwestern Illinois, Freeport Memorial Hospital; University of Florida School of Medicine; Illinois Medical Assistants Association, Pekin; Northern Michigan University, Marquette, Mich.; American College of Surgeons Committee on Trauma; DuPage County Medical Assistants Association; University of Michigan, Ann Arbor, Mich.; Graduate Nurses Disaster Institute, Rockford; University of Florida Physiotherapy and Laboratory classes, Gainesville; Illinois Federation of Women's Clubs, Evanston; Illinois Association of Professions, Chicago; Prince of Peace Church, Addison; WBKB-TV; WTVP-TV, Decatur; WBBM—Mal Bellairs Tie Line—(3 shows); WBBM—Lee Phillips Show.

Conclusion

Committee activities planned for 1966-67 include:

1. Further distribution of the MSHT films for presentations on television and encouraging live MSHT presentations by various paramedical groups.

2. Increase promotional activities regarding the construction of fallout shelters under highways. The committee plans to do this through the Illinois Association of Professions and Drs. Wigner and Breese of the Atomic Energy Commission.

3. Conduct an intensive educational campaign regarding the danger of using glass in the construction of buildings.

In closing, the committee expresses its deepest gratitude to the ISMS Woman's Auxiliary for the time and encouragement they have given our program; to the Illinois Department of Public Health, the U. S. Public Health Service and the Illinois Department of Civil Defense for their continued support, and last but not least, to the members of our Public Relations Division who have done such a magnificent job in promoting and implementing our projects.

Max Klinghoffer, *Chairman*

Jack R. Baldwin — Harold C. Lueth
Richard V. Lee — Carl F. Steinhoff

Auxiliary: Mrs. Bruno Beinoris

ADVISORY COMMITTEE TO STUDENT AMA
PR-8

The second annual ISMS Student AMA Conference, scheduled April 23 at the Chicago-Sheraton Hotel, was the committee's major project during 1965-66.

For the first time, all Chicago area medical students, interns, residents and their wives were invited — nearly 14,000 persons. The program was centered around the theme, "The

Role of the Physician in Community Health."

Thanks to a grant from Lederle Laboratories, Pearl River, N. Y., the day-long program which included a luncheon, a special afternoon session for wives and a reception at the end of the Conference cost ISMS nothing.

Six prominent speakers highlighted the program: Dr. Frank Locke, Adrian, Mich., "Sex Education in the Community"; Richard P. Bergen, of the AMA's Law Department, "How to Stay Out of Legal Difficulty"; Dr. Beverley T. Mead, Creighton University School of Medicine, Omaha, Neb., "Alcoholism in the Community"; Dr. James B. Donaldson, Philadelphia, Pa., "The Physician and His Civic Responsibility": Tennyson Guyer, Public Relations Director, Cooper Tire & Rubber Co., Findlay, Ohio, as luncheon speaker; and Arthur J. Snider, Chicago Daily News science writer, who served as panelist.

To further acquaint SAMA medical students with the principles of organized medicine and to assist them in the preparation of their professional careers, the committee also:

Contributed $1,000—$200 each to Northwestern, Illinois, Chicago, Loyola's Stritch School of Medicine, and Chicago Medical school —to enable representatives of each of the SAMA chapters to attend the national SAMA convention in Los Angeles.

Sponsored several chapter dinner meetings.

Invited chapter presidents to attend meetings of the ISMS Board of Trustees to familiarize them with the workings of organized medicine.

Assisted SAMA in formation of a first-in-the-nation SAMA-ALSA (American Law Student Association) Medical-Legal Committee designed to consider problems of mutual interest.

Continued support of SAMA chapter programs by printing chapter and auxiliary newsletters and through various news releases.

Extended an invitation to SAMA members to attend the ISMS convention in May.

Maurice M. Hoeltgen, *Chairman*

Ralph E. Dolkart — Louis R. Limarzi
Hilger Perry Jenkins — David B. Radner

MEDICINE AND RELIGION COMMITTEE PR-9

The primary function of this committee is to initiate and coordinate medicine and religion activities on the local level through county societies.

While the committee did not hold a formal meeting during the past year, several projects have been proposed for implementation in 1966-67.

One of the most interesting is the production of a 13-part radio series based on case studies of physician- patient-clergy relationships. The series, which would be made available to county medical societies throughout the state, would be produced in cooperation with the local ministerial association. Not only would this provide for a balanced program, but it would also serve to strengthen the bond between the medical profession and clergy in that area.

In addition, the committee expressed a desire to launch a field service program to encourage and assist those county societies in the formation of medicine and religion committees, as well as in the implementation of local programs.

We are pleased to report that nine county societies have already initiated medicine and religion activities in their areas. They include: Chicago, Will-Grundy, LaSalle, DeKalb, Peoria, Coles-Cumberland, McLean, Tazewell and Fayette.

Joseph R. Mallory, *Chairman*

Eli L. Borkon — Charles W. Pfister
Paul S. Rhoads

Ex-Officio: J. Ernest Bread
Caesar Portes

Auxiliary: Mrs. Wendell F. Roller



Resolution # 66M-1

Introduced by: Jackson County Medical Society

Subject: Action by the House of Delegates relative to Annual Dues

Referred to: Reference Committee on Administration "A"

The Jackson County Medical Society is a component of the Illinois State Medical Society in good standing and through the Illinois State Society, of the American Medical Association in good standing; and

The members of the Jackson County Medical Society feel that their interests are closely bound up with the interests of the State Society and the National Society; and

The members of the Jackson County Medical Society have always wholeheartedly supported the State Society and the National Society, and hope to do so in the future. In order for the State and National Society to deserve this support, the members of the Jackson County Medical Society feel that when a major decision is to be made it should be after appropriate debate and discussion by all of the practicing physicians involved.

Be it therefore hereby

RESOLVED, That we, the members of the Jackson County Medical Society, hereby request that it be incorporated in the bylaws of the Illinois State Medical Society that there will be *no increase in dues* for the membership of the Illinois State Medical Society except that this increase be voted on by the general house of delegates of the Illinois State Medical Society in the *regular annual meeting*. This is to permit the Delegates to be properly instructed by their local societies and to permit an open and free discussion of any such proposed increase in dues.

The above resolution is being submitted by an unanimous vote of the Jackson County Medical Society, November 23, 1965.

Resolution # 66M-2

Introduced by: Madison County Medical Society

Subject: Cooperation with HEW under PL 89-97

Referred to: Reference Committee on Economics and Insurance

WHEREAS: We the members of the Madison County Medical Society are here assembled for the first time since the enactment into law of the recent amendments to the Social Security Act, including Public Law No. 89-97, the so called "Medicare Bill"

AND WHEREAS, We have individually and independently concluded that these changes will be detrimental to the care of our patients—

AND WHEREAS, We believe that the majority of the patients we serve will come to regret and be dissatisfied with this law

AND WHEREAS: The Board of Trustees of the AMA, taking a public stand, has decided on a program of Planned Cooperation INCLUDING GIVING ADVICE AND guidance to the Secretary of Health, Education and Welfare and his representatives.

AND WHEREAS: such a policy has never previously been endorsed by the AMA House of Delegates, nor at a state level by the Illinois State Medical Society House of Delegates, as it constitutionally should have been.

NOW THEREFORE BE IT RESOLVED:

That the Madison County Medical Society disapproves of this nefarious philosophy of collaboration.

And be it further resolved:

That our members will make every possible effort to educate other members of the Illinois State Medical Society, including our AMA Delegates to the inevitable truth of our convictions.

And be it firmly resolved among our membership:

That if we are not going to be fully and honestly represented at a state or national level it shall be honorable, ethical, and moral for any member by his own choice and decision either not to participate in the Medicare program, not to collaborate with it or not to belong to the Illinois State Medical Society and/or the American Medical Association and yet retain without prejudice full privileges and standing in our local society, including the right to be elected or appointed to any office.

Resolution # 66M-3

Introduced by: Madison County Medical Society

Subject: New "Scientific Membership" for AMA Requested

Referred to: Reference Committee on Miscellaneous Business

WHEREAS there has been a tendency in recent years for the organizational and political activities of the AMA to overshadow its essential and original scientific purposes,

AND WHEREAS many ethical practicing physicians have come to honestly disagree with these organizational socialized and political AMA activities, so that they no longer believe that the AMA can represent them fairly,

NOW THEREFORE BE IT RESOLVED:

That a new type of AMA Membership be created and recognized, with the following characteristics:

1. No voting rights in the AMA or constitutional societies thereof.
2. No representation to the House of Delegates, Board of Trustees or standing committees.
3. Minimal dues—essential only to support a greatly curtailed role—endorsed by this special group.
4. Invitation to all AMA clinical meetings, scientific exhibits and a share in postgraduate medical education.
5. An opportunity to maintain subscriptions to the AMA Journal and other scientific or educational publications if desired.
6. An opportunity to share in those activities of the AMA which are strictly limited to the art and science of medicine and the maintenance of its ethical standards.

Resolution # 66M-4

Introduced by: Vermilion County Medical Society

Subject: Usual and Customary Charges for Services Rendered

Referred to: Reference Committee on Economics and Insurance

Although it has been traditional in the past for physicians to offer their services to the indigent at little or no cost, with the coming involvement of government in the financial care of the aged and other indigents, this free service is no longer a personal service between patient and physician. The government neither expects, nor gets, any discount for services rendered by other vendors to the aged or the indigent.

Therefore, the Vermilion County Medical Society wishes to go on record as being opposed to any arrangement with *any* government agencies except for compensation in accordance with the usual and customary charges for the services rendered. The Society recommends that any committees negotiating with federal agencies on a state or national level insist on such arrangements, and that negotiations with existing agencies for care of the aged or the indigent be re-opened to bring payments to physicians up to such usual and customary charges.

Resolution # 66M-5

Introduced by: Michael R. Saxon, First Vice President

Subject: Adoption of "Free Society Philosophy"

Approval of Program for Continuing Education for those Responsible for carrying out this Program

Referred to: Reference Committee on Administration "B"

WHEREAS, The ISMS on many occasions through its official representatives has demonstrated its approval of political, social and economic concepts that promote individual freedom and liberty, and

WHEREAS, Many of the programs sponsored by the ISMS have been ineffective in attaining desired goals, and

WHEREAS, Many of our failures can be attributed to a lack of understanding of the basic concepts of libertarian philosophy, and

WHEREAS, Methodology in communicating ideas that will promote freedom in medicine (only possible in a free society) must be pinpointed and effective, be it therefore

RESOLVED, That the ISMS adopt "The Free Society Philosophy" as a basis for its policies and actions, and be it further

RESOLVED, That by delineation and definition this philosophy preserve and promote:

1. The concept of limited power for our government
2. Individual freedom to create and perform peacefully with one's God-given talents and acquired knowledge
3. Free and open markets for all products and services, including the licensed practice of medicine
4. Economic growth by the investment of private and not government capital

be it further

RESOLVED, That the ISMS set up a program of continuing education for its membership and the general public to promote the free society as defined and delineated, and be it further

RESOLVED, That those responsible for carrying out this program have specific instructions in methodology and in the art and science of communicating effectively in order to motivate people to make our programs more successful.

Resolution # 66M-6

Introduced by: George C. Turner, M.D., for the Tuberculosis Committee

Subject: Tuberculosis Vaccination

Referred to: Reference Committee on Publications and Scientific Services

WHEREAS, the promoters of BCG vaccine are receiving newspaper publicity for a questionable preventive drug that has little value in Illinois; and

WHEREAS, the Tuberculosis committee maintains the position taken on March 26, 1963, regarding BCG, that "The Committee confirm the statement of the Tuberculosis Control Advisory Committee which says: Widespread BCG vaccination in Illinois, including

Chicago, is contraindicated today because it interferes with the use of the tuberculin test as an epidemiologic and diagnostic tool," therefore,

BE IT RESOLVED, That the Illinois State Medical Society re-affirm the official position taken by the Tuberculosis Committee on March 26, 1963, regarding BCG.

Resolution # 66M-7

Introduced by: Board of Trustees
Subject: Joint Husband-Wife Membership in ISMS and Auxiliary
Referred to: Reference Committee on Administration "B" Reports of Officers

WHEREAS, The Auxiliary is dedicated to promote the aims and objectives of the medical societies on every level, including those concerned with legislation on a local and state, as well as national level, and in other socio-economic endeavors, and

WHEREAS, The Auxiliary has demonstrated its ability and willingness to serve the medical profession by contributing substantial amounts to the Benevolence Committee, to the AMA-ERF, to scholarships for student nurses, for activities in the health careers field, and

WHEREAS, The Auxiliary cannot serve the profession to the best of its potential nor can it educate the doctors' wives who are not members, without the support and encouragement of each medical society, and

WHEREAS, The House of Delegates of the AMA unanimously adopted a resolution at the 1964 Clinical Session strongly urging each state and local medical society to support fully and to aid and encourage the Woman's Auxiliary in all its endeavors, particularly in the joint husband-wife membership project, and

WHEREAS, There is a large gap between the membership in the Illinois State Medical Society and that of our Auxiliary, and the one way in which this gap can be closed is through creation of a husband-wife membership, through which the doctor's wife automatically becomes an Auxiliary member when her husband is accepted into the medical society, therefore be it

RESOLVED, That the House of Delegates of the ISMS commend the Auxiliary for all its laudable activities, and be it further

RESOLVED, That the House of Delegates endorses this plan and votes its approval, recommending to each component medical society that it adopt this joint husband-wife membership project and extend the Auxiliary membership at both the State and AMA levels.

Resolution # 66M-8

Introduced by: Will-Grundy Medical Society
Subject: Support for Health Careers Council
Referred to: Reference Committee on Public Relations

WHEREAS, It is important that students be guided toward medical and paramedical careers, and

WHEREAS, The majority of individual physicians lacks the time, does not have the current information and frequently is not asked to participate in career guidance activities, and

WHEREAS, The Health Careers Council of Illinois has the experience, the current information and is recognized as a valued participant in career guidance activities, now therefore be it hereby

RESOLVED, That The Illinois State Medical Society continue, and if possible, increase its support of the Health Careers Council of Illinois.

Tickets to "Hello Dolly" with Carol Channing
and dinner at the Blackhawk Restaurant

Wednesday, May 18

Benefit of the Chicago Auditorium Theatre Restoration

Tickets $25.00 each ($10 tax deductible)

Send check to:
A. Wales Williamson
The Auditorium Theatre Council
310 South Michigan Avenue
Chicago, Illinois 60605

Ticket Supply Limited **Write Now!**

(no tickets available from box office)

"Early Diagnosis"

Program Summary

ISMS Convention

Saturday, May 14

9:00 a.m. Legislative Committee
French Room 107

9:00 a.m. Finance and Executive Committees
Time Room 110

12:30 p.m. Board of Trustees Luncheon
Jade Room 103

1:30 p.m. Board of Trustees Meeting
Crystal Room

6:00 p.m. Board of Trustees Dinner
Starlight Room

Sunday, May 15

9:00 a.m. Public Affairs Committee
French Room 107

10:00 a.m. Registration of Officers and Delegates
Mezzanine

10:00 a.m. Reference Committee Chairmen
Time Room 110

12:00 noon Public Affairs Committee Luncheon
Orchid Room 106

1:00 p.m. Individual district meetings as called

2:00 p.m. Credentials Committee
French Room 107

3:00 p.m. House of Delegates
Louis XVI Room

3:00 p.m. Auxiliary Registration
Lobby

6:00 p.m. Delegates Buffet
George Bernard Shaw Room

6:00 p.m. Illinois Society of Obstetricians and Gynecologists Board Dinner
Life Room 108

7:30 p.m. Reference Committees:
Administration "A" (Finances)
Old Chicago Room 101
Administration "B" (Reports of Officers)
Jade Room 103
Constitution & Bylaws
Holiday Room 105
Economics and Insurance
Gold Room 114
Legislation and Public Affairs
Ruby Room 113
Miscellaneous Business
Orchid Room 106
Publications and Scientific Services
Time Room 110
Public Relations
French Room 107

Monday, May 16

8:00 a.m. Illinois Surgical Society
Cook County Hospital

8:00 a.m. Board of Trustees Breakfast
French Room 107

8:30 a.m. Registration
Mezzanine

8:30 a.m. Auxiliary Pre-Convention Board Meeting
Orchid Room 106

8:30 a.m. Auxiliary Registration
Lobby

8:30 a.m. Illinois Obstetrical and Gynecological Society
Gold Room 114

9:00 a.m. Auxiliary House of Delegates
George Bernard Shaw Room

9:00 a.m. Occupational Health
Crystal Room

9:00 a.m. Utilization Workshop
Bal Tabarin

10:00 a.m. Illinois Mental Health Department Physicians Association
Ruby Room 113

11:00 a.m. Formal Opening of Exhibits

12:00 noon Illinois Society of Obstetricians and Gynecologists Luncheon
Jade Room 103

12:30 p.m. Impartial Medical Testimony Luncheon
Old Chicago Room 101

12:30 p.m. Utilization Workshop Luncheon
Bal Tabarin

1:00 p.m. Section on Anesthesiology
Ruby Room 113

1:30 p.m. Section on Surgery and Illinois Surgical Society
Louis XVI Room

1:30 p.m. Section on Neurology and Psychiatry
Crystal Room

3:00 p.m. Auxiliary Reception
House on the Roof

4:00 p.m. IMPAC Annual Meeting
Jade Room 103

4:00 p.m. Auxiliary President-Elect Meeting
Orchid Room 106

6:00 p.m. Public Affairs Dinner
Bal Tabarin

6:00 p.m. University of Illinois Alumni Dinner
Crystal Room

Tuesday, May 17

8:00 a.m. Auxiliary Registration
Lobby

8:00 a.m. Board of Trustees Breakfast
French Room 107

8:00 a.m. Auxiliary House of Delegates
Louis XVI Room and Crystal Room

8:30 a.m. Registration
Mezzanine

8:30 a.m. Section on Obstetrics and Gynecology
Ruby Room 113

8:30 a.m. Section on Allergy
Jade Room 103

9:00 a.m. Exhibits Open

9:00 a.m. Section on Internal Medicine
Gold Room 114

10:30 a.m. Illinois Chapter, American College of Chest Physicians
Old Chicago Room 101

12:30 p.m. Illinois Academy of Preventive Medicine Luncheon
Jade Room 103

12:30 p.m. Chest Physicians Luncheon
Old Chicago Room 101

12:30 p.m. Fifty Year Club Luncheon
George Bernard Shaw Room

1:00 p.m. Section on Radiology
Crystal Room

1:30 p.m. Section on Physical Medicine
Gold Room 114

1:30 p.m. Credentials Committee
Louis XVI Foyer

2:00 p.m. House of Delegates
Louis XVI Room

2:00 p.m. Section on Preventive Medicine
Ruby Room 113

6:00 p.m. Section on Pathology Dinner
Ruby Room 113

6:00 p.m. Past Presidents' Dinner
Starlight Room

8:30 p.m. Gas Light Party
Ballroom

Wednesday, May 18

8:00 a.m. AMA Delegates Breakfast
Orchid Room 106

8:00 a.m. Auxiliary Registration
Lobby

8:00 a.m. Board of Trustees Breakfast
French Room 107

8:30 a.m. Registration
Mezzanine

8:30 a.m. Auxiliary House of Delegates
George Bernard Shaw Room

8:30 a.m. Section on Eye, Ear, Nose and Throat
Crystal Room

8:30 a.m. Section on Pathology
Gold Room 114

8:30 a.m. Section on Pediatrics
Louis XVI Room

9:00 a.m. Exhibits Open

9:00 a.m. Section on Dermatology
Jade Room 103

11:00 a.m. Illinois Society of Internal Medicine
Ruby Room 113

12:00 noon Illinois Academy of General Practice Luncheon
Old Chicago Room 101

12:30 p.m. Illinois Academy of Pediatrics Luncheon
Jade Room 103

1:00 p.m. Auxiliary Installation Luncheon
Bal Tabarin

1:30 p.m. Illinois Academy of General Practice Board Meeting
Time Room 110

1:30 p.m. Credentials Committee
Louis XVI Foyer

2:00 p.m. Camp Lecture—House of Delegates
Louis XVI Room

3:00 p.m. House of Delegates
Louis XVI Room

3:00 p.m. Pathology Slide Seminar
Hektoen Institute

3:00 p.m. Auxiliary Post-Convention Meeting
Orchid Room 106

3:00 p.m. Chicago Medical School Mental Health Program
George Bernard Shaw Room

5:00 p.m. Exhibits Close

6:00 p.m. Board of Trustees Dinner
Gold Room 114

6:00 p.m. Chicago Medical School Dinner
Bal Tabarin

REFERENCE COMMITTEE MEETINGS

SUNDAY, MAY 15	7:30 P.M.
ADMINISTRATION "A" (FINANCES)	OLD CHICAGO ROOM 101
ADMINISTRATION "B" (REPORTS OF OFFICERS)	JADE ROOM 103
CONSTITUTION AND BYLAWS	HOLIDAY ROOM 105
ECONOMICS AND INSURANCE	GOLD ROOM 114
LEGISLATION AND PUBLIC AFFAIRS	RUBY ROOM 113
MISCELLANEOUS BUSINESS	ORCHID ROOM 106
PUBLICATIONS AND SCIENTIFIC SERVICES	TIME ROOM 110
PUBLIC RELATIONS	FRENCH ROOM 107

BOARD OF TRUSTEES MEETINGS

SATURDAY, MAY 14	LUNCHEON	12:30 P.M.	JADE ROOM 103
SATURDAY, MAY 14	MEETING	1:30 P.M.	CRYSTAL ROOM
SATURDAY, MAY 14	DINNER	6:00 P.M.	STARLIGHT ROOM
MONDAY, MAY 16	BREAKFAST	8:00 A.M.	FRENCH ROOM 107
TUESDAY, MAY 16	BREAKFAST	8:00 A.M.	FRENCH ROOM 107
WEDNESDAY, MAY 18	BREAKFAST	8:00 A.M.	FRENCH ROOM 107
WEDNESDAY, MAY 18	DINNER	6:00 P.M.	GOLD ROOM 114

"Early Diagnosis"
Convention Program by Days

ILLINOIS SURGICAL SOCIETY

Monday, May 16 — **Surgical Amphitheatre, Cook County Hospital**

Chairman of Surgical Symposium:
Richard H. Lawler, M.D.

8:30-9:30 a.m. Moderator:
Charles B. Puestow, M.D.

"Choice of Operation for Gastric Pathology"
Frederick dePeyster, M.D., Surgeon

"Complications of Gastric Surgery"
Donald D. Kozoll, M.D.

"Management of Perforation and Fistula"
John M. Beal, M.D.

9:30-11:00 a.m. Moderator:
Manuel E. Lichtenstein, M.D.

"Difficult Problems in Biliary Tract Surgery"
E. Lee Strohl, M.D., Surgeon

"Traumatic Injuries to Biliary Tract"
Willis G. Diffenbaugh, M.D.

"Surgical Significance of Trauma to the Pancreas"
W. James Gillesby, M.D.

11:00 a.m.-noon — **Hektoen Institute**

"Massive Gastric Hemorrhage"
Nathan A. Womack, M.D., Chapel Hill, N.C., Professor of Surgery, Chairman, Department of Surgery, University of North Carolina Medical School

8:00-10:30 a.m. — **Opr. Room "A"**

Moderator: George E. Block, M.D.

"Tumor of the Colon: What Would You Do?"
Robert E. Baker, M.D., Surgeon

"Complications Following Colon Surgery"
Peter A. Rosi, M.D.

"Palliative Therapy for Inoperable Patient with Carcinoma of Colon"
John T. Reynolds, M.D. and J. C. Thomas Rogers, M.D.

8:00-10:30 a.m. — **Opr. Room "B"**

Moderator: Arthur DeBoer, M.D.

"Reconstructive Surgery of Occlusive Disease of Femoral Artery"
Robert J. Freeark, M.D., Surgeon

"Emergence Endarterectomy for Acute Occlusion"
William S. Dye, M.D.

"Aortoiliofemoral Endarterectomy"
Geza deTakats, M.D.

8:00-10:30 a.m. — **Opr. Room "C"**

Moderator: Hiram T. Langston, M.D.

"Management of Cardiac and Vascular Diseases of Thoracic Cavity"
Milton Weinberg, Jr., M.D., Surgeon

Discussion
Jack C. Cooley, M.D. and Robert A. De Bord, M.D.

8:00-10:30 a.m. — **Opr. Room "D"**

Moderator: Robert L. Schmitz, M.D.

"Diagnosis and Treatment of Solitary Nodule of Thyroid Gland"
Frank A. Folk, M.D., Surgeon

Discussion
Sheldon Waldstein, M.D., Everett P. Coleman, M.D. and Harold P. McGinnes, M.D.

8:00-10:30 a.m. — **Opr. Room "E"**

Moderator: Augusta Webster, M.D.

"Vaginal Hysterectomy and Repair of Posterior Culdesac Hernia"
Walter J. Reich, M.D., Surgeon

Discussion
Mitchell J. Nechtow, M.D., Kenneth H. Schnepp, M.D., Russell M. Jensen, M.D. and W. M. McMillan, M.D.

8:00-10:30 a.m. — **Cook County Children's Hospital, 5th floor**

Moderator: Sumner L. Koch, M.D.

"Modern Technique in Management of Burns"
John A. Boswick, M.D., Surgeon

Discussion
Randall McNally, M.D. and Burton C. Kilbourne, M.D.

ILLINOIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Monday, May 16 **Gold Room 114**

8:30 a.m. Business Meeting

9:30 a.m. "Lesions of the Cervix"
(Kodachrome slides)
Carl Burpo, M.D., Attending, St. Elizabeth's and Belleville Memorial Hospital, Belleville

Case Report
William Curtis, M.D., Attending, St. John's and Memorial Hospitals, Springfield

"Clomiphene in Regulation of Ovulation in Normal Women"
John Boutselis, M.D., Assistant Professor, Ohio State University, College of Medicine; Chairman, Department of Obstetrics and Gynecology, Mt. Carmel Hospital, Columbus, Ohio

12 noon Luncheon **Jade Room 103**

1:00-4:00 p.m. "Teenage Problems—A Panel Discussion"
Moderator: Hubert Allen, M.D., Clinical Instructor, Obstetrics and Gynecology, Washington University; Attending, Alton Memorial and St. Joseph's Hospital, Alton

Panelists:

"Teenage Pregnancy"
Augusta Webster, M.D., Professor, Obstetrics and Gynecology, Northwestern University Medical School

"Menstrual Disorders in Teenagers"
John Huffman, M.D., Professor, Obstetrics and Gynecology, Northwestern University Medical School

"Sex Education of Teenagers"
Franklin Fitch, M.D., Associate Professor, Dermatology, Northwestern University Medical School; Executive Director, Illinois Social Hygiene League

"Emotional Problems of Teenagers"
Margaret Pijan, M.D., Associate, Pediatrics, Northwestern University Medical School; Director, Child Guidance Clinic

"Our Responsibility to the Teenager"
Rev. Christian A. Hovde, Ph.D. (Anatomy), Director, Bishop Anderson Foundation, Medical Center, Chicago; Lecturer in Anatomy, University of Illinois College of Medicine

OCCUPATIONAL HEALTH

Monday, May 16 **Crystal Room**

9:00-9:15 a.m. Opening—Edward C. Holmblad, M.D., Chairman
Remarks—Henry Howe, M.D., Director, AMA Department of Occupational Health

9:15-10:30 a.m. "Workmen's Compensation Panel"
Moderator: Henry Howe, M.D.

"Medical Aspects of Workmen's Compensation"
John Post, M.D., Medical Director, Zenith Radio Corp., Chicago

"Injuries Covered by Workmen's Compensation"
John G. Meyer, Jr., M.D., Springfield

"Cooperation—Medical Societies and Industrial Commissions"
Ralph E. Gintz, Industrial Commissioner, State of Wisconsin

Questions and Discussion

10:30-10:45 a.m. Break

10:45-11:45 a.m. "Alcoholism"
Edward C. Holmblad, M.D., Moderator

"Alcoholism and Absenteeism"
J. M. Colthart, M.D., Medical Director, Western Electric, Chicago

"Alcoholism and the Employee"
Kenneth Rouse, Director of Rehabilitation Services, Kemper Insurance Co., Chicago

"Rehabilitating the Alcoholic"
Mr. "X", member of Alcoholics Anonymous

Questions and Discussion

11:45 a.m. Concluding Remarks
Edward C. Holmblad, M.D.

ILLINOIS MENTAL HEALTH DEPARTMENT PHYSICIANS ASSOCIATION

Monday, May 16 **Ruby Room 113**
Program Director: Werner Tuteur, M.D.

10:00 a.m. "New Trends Regarding Professional Services Within the Illinois Department of Mental Health"
Abel G. Ossorio, Ph.D., Director, Division of Professional Services, Illinois Department of Mental Health

IMPARTIAL MEDICAL TESTIMONY

Monday, May 16 **Old Chicago Room 101**

12:30-2:00 p.m. Luncheon

Chairman: Clinton L. Compere, M.D.

"Impartial Medical Testimony Rules"
Hon. William J. Campbell, Chief Judge, Federal Court, Northern District of Illinois, Chicago

"IMT in Illinois Circuit Courts"
Carl Rolewick, Assistant Director, Administrative Office, Illinois Courts, Chicago

"Reorganization and Functioning of Illinois Court System"
Hon. John S. Boyle, Chief Judge, Circuit Court of Cook County, Chicago

SECTION ON ANESTHESIOLOGY

Monday, May 16 **Ruby Room 113**

Chairman: John T. Nelson, M.D., Elgin

1:00 p.m. "A Need for a Fresh Look"
James E. Eckenhoff, M.D., Professor and Chairman, Department of Anesthesia, Northwestern University Medical School

2:00 p.m. "A Little Slice of Death"
John W. Lauer, M.D., Associate Attending Staff in Psychiatry, Wesley Memorial Hospital; Associate in Department of Psychiatry, Northwestern University Medical School

2:30 p.m. Exhibit Break

3:00 p.m. "Metabolic Diseases and Anesthesiology"
Robert Ryan, M.D., Associate Professor of Medicine, University of Illinois College of Medicine; Chief of Endocrinology Clinic, Research and Educational Hospital

3:30 p.m. "Allergy and Anesthesia: The True and Imagined Risks"
Max Samter, M.D., Professor of Medicine, University of Illinois College of Medicine

4:00 p.m. "Radiation Hazard and Radiology in the Operating Room"
I. E. Kirsh, M.D., Chief, Department of Radiology, Hines Veterans Administration Hospital, Associate Professor of Radiology, University of Illinois College of Medicine

SECTION ON SURGERY AND ILLINOIS SURGICAL SOCIETY

Monday, May 16 **Louis XVI Room**

Chairmen: James A. Rooney, M.D., Oak Park, George E. Block, M.D., Chicago

1:30 p.m. Panel: "Early Diagnosis and Surgical Management of Carcinoma"

Moderator: John L. Keeley, M.D., Chairman, Department of Surgery, Stritch School of Medicine, Loyola University

"Genitourinary Neoplasms"
Vincent J. O'Conor, Jr., M.D., Assistant Professor of Urology, Northwestern University Medical School

"Malignancies in Childhood"
William L. Donnellan, M.D., Associate, Department of Surgery, Northwestern University Medical School

"Neourosurgical Pathology"
David C. Voris, M.D., Clinical Associate, Neurosurgery, University of Illinois College of Medicine

2:30 p.m. "Rationale for the Surgical Treatment of Varices in Cirrhosis"
Nathan A. Womack, M.D., Professor and Chairman, Department of Surgery, University of North Carolina Medical School

3:45 p.m. Panel: "Malignant Lesions of the Breast"

Moderator: George E. Block, M.D., Associate Professor of Surgery, University of Chicago School of Medicine
Louis P. River, M.D., Clinical Professor of Surgery, Stritch School of Medicine, Loyola University
T. Howard Clarke, M.D., Professor of Surgery, Northwestern University Medical School
Melvin Grieme, M.D., Associate Professor of Radiology, University of Chicago School of Medicine

"Intraductal Papilloma"
William H. Requarth, M.D., Associate Professor of Surgery, University of Illinois College of Medicine

SECTION ON NEUROLOGY AND PSYCHIATRY

Monday, May 16 **Crystal Room**

Chairman: Harold E. Himwich, M.D., Galesburg

Psychiatry: The Use of Psychotropic Drugs in General Practice

1:30 p.m. "The General Use of Psychotropic Drugs"
Jackson A. Smith, M.D., Professor and Chairman, Department of Psychiatry, Stritch School of Medicine, Loyola University
David Swanson, M.D., Clinical Assistant Professor of Psychiatry and Assistant Chairman, Department of Psychiatry and Neurology, Stritch School of Medicine, Loyola University

2:00 p.m. "Tranquilizers in General Practice"
Werner Tuteur, M.D., Clinical Director, Elgin State Hospital; Clinical Associate Professor of Psychiatry, Stritch School of Medicine, Loyola University

2:30 p.m. "The Use of Psychoactive Drugs in Children"
John S. Werry, M.B., Research Psychiatrist, Children's Research Center and Assistant Professor of Psychiatry, University of Illinois, Urbana

3:00 p.m. Exhibit Break

Neurology: Neurological Conditions Encountered in General Practice

3:30 p.m. "The Management of Headache"
Seymour L. Pollack, Assistant Superintendent, Galesburg State Research Hospital

4:00 p.m. "Diagnosis of Multiple Sclerosis: Recognition of Early Cases, and Differentiation from Other Disorders More Amenable to Treatment"
Joseph A. Luhan, M.D., Professor of Neurology and Psychiatry, Stritch School of Medicine, Loyola University

4:30 p.m. "Convulsive Disorders: Their Early Recognition and Management"
Harold Koenig, M.D., Ph.D., Chief, Neurology Service, V. A. Research Hospital; Professor of Neurology and Psychiatry, Northwestern University Medical School

IMPAC ANNUAL MEETING

Monday **Jade Room 103**
4:00 p.m.

PUBLIC AFFAIRS DINNER

Monday **Bal Tabarin**
6:00 p.m. "Farmers' Interest in Political Education and Action"
Charles B. Shuman, President, American Farm Bureau Federation

SECTION ON ALLERGY

Tuesday, May 17 **Jade Room 103**
Chairman: John Hyde, M.D., Oak Park

8:30 a.m. "Prevention and Treatment of Severe Insect Sting Reactions"
Terumasa Miyamoto, M.D., University of Tokyo Medical School, Tokyo, Japan; Fellow, Northwestern University Medical School

9:00 a.m. "Allergic Reactions to Topical Medications"
Fred Levit, M.D., Assistant Professor of Dermatology, Northwestern University Medical School

9:30 a.m. "Importance of Early Diagnosis and Management of Bronchial Asthma"
Robert E. Smith, Major, M.C., USAF, Chief, Section of Allergy and Immunology, Wilford Hall, USAF Hospital, Lackland AFB, Texas

10:30 a.m. Exhibit Break

11:00 a.m. "Reactions to Antibiotics—Prevention and Treatment"
H. L. Moffet, M.D., Assistant Professor of Pediatrics, Northwestern University Medical School; Children's Memorial Hospital, Chicago

11:30 a.m. "Histamine Release from Peripheral Leukocytes as a Result of Allergic Reactions"
J. J. Pruzansky, Ph.D., Associate Director, Allergy Research Laboratory, Northwestern University Medical School

SECTION ON OBSTETRICS-GYNECOLOGY

Tuesday, May 17 **Ruby Room 113**
Chairman: Alan B. Sampson, M.D., Oak Park

8:30 a.m. "Cytology and Gynecology"—Panel
Moderator: Elizabeth A. McGrew, M.D., Professor of Pathology, University of Illinois College of Medicine; Pathologist, Research and Educational Hospitals, University of Illinois

Panelists:

Grant C. Johnson, M.D., Chief Pathologist, Memorial Hospital, Springfield; Associate Professor of Pathology, University of Illinois College of Medicine

John M. Collins, M.D., Senior Instructor, Ob-Gyn, St. Louis University School of Medicine; St. Elizabeth's and Memorial Hospitals, Belleville, Illinois

Lawrence L. Hirsch, M.D., General Practitioner, Attending Staff, Illinois Masonic Hospital, Chicago

10:00 a.m. Exhibit Break

10:30 a.m. "Tumor Chemotherapy in Obstetrics and Gynecology"

John I. Brewer, M.D., Ph.D., Professor, Ob-Gyn, Northwestern University Medical School; Chief Ob-Gyn, Passavant Memorial Hospital

11:30 a.m. "The Use of the Intrauterine Device"

E. Harold Ennis, M.D., Senior Attending, St. John's and Memorial Hospitals, Springfield

SECTION ON INTERNAL MEDICINE

Tuesday, May 17 — Gold Room 114

Chairman: Angelo P. Creticos, M.D., Chicago

9:00 a.m. Panel: "Bringing the Arthridites Up to Date"

Moderator: Arnold Black, M.D., Chief, Arthritis Clinic, Mt. Sinai Hospital; Clinical Associate Professor of Medicine, Chicago Medical School

Frank R. Schmid, M.D., Associate Professor of Medicine, Northwestern University Medical School

Arthur A. Rodriquez, M.D., Professor of Physical Medicine and Rehabilitation, Stritch School of Medicine, Loyola University

Francis M. Howard, M.D., Assistant Clinical Professor of Orthopedic Surgery, University of Illinois College of Medicine

11:00 a.m. Exhibit Break

ANNUAL MEETING ILLINOIS CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS

Tuesday, May 17 — Old Chicago Room 101

10:30 a.m. "Diagnostic Problems in Chest Disease"—Panel Discussion

Leon Love, M.D., Director, Diagnostic Radiology, Cook County Hospital; Associate Professor of Radiology, Chicago Medical School

Thomas W. Shields, M.D., Attending Surgeon, Passavant Memorial Hospital; Associate Professor of Surgery, Northwestern University

Gordon L. Snider, M.D., Chief, Division of Thoracic Medicine, Mount Sinai Hospital; Professor of Medicine, Chicago Medical School

David M. Spain, M.D., Director of Pathology, Brookdale Hospital Center, Brooklyn, N.Y.; Professor of Pathology, State University of New York Downstate Medical School, Brooklyn

12:30 p.m. Luncheon—Old Chicago Room 101

1:30 p.m. "Pulmonary Defense Mechanisms—Modern Concepts"

David M. Spain, M.D., Director of Pathology, Brookdale Hospital Center, Brooklyn, N.Y.

No registration fee. All physicians are cordially invited to attend.

PUBLIC HEALTH LUNCHEON

Tuesday, May 17 — Jade Room 103

12:30 p.m. Section on Preventive Medicine and Public Health, Illinois Academy of Preventive Medicine, Illinois Chapter of American Association of Public Health Physicians and Illinois Association of Medical Health Officers.

Open to all physicians.

"Preventive Medicine Activities of the American Medical Association"—Symposium

Moderator: Donald A. Dukelow, M.D., President, Illinois Academy of Preventive Medicine

Panelists: Fred V. Hein, Ph.D., Director, Department of Health Education, Division of Socio-Economic Activities, AMA

Henry Howe, M.D., Director, Department of Occupational Health, Division of Socio-Economic Activities, AMA

James Telfer, M.D., Director, Department of Environmental Health, Division of Socio-Economic Activities, AMA

FIFTY-YEAR CLUB

Tuesday — George Bernard Shaw Room

12:30 p.m. Luncheon

The era of 1916 re-created to honor new members of the 50-Year Club

SECTION ON RADIOLOGY

Tuesday, May 17 — Crystal Room

Chairman: J. H. Goodlad, M.D., Peoria

1:00 p.m. "Some Clinical and Radiological Aspects of Cerebrovascular Occlusive Disease"

David Reese, M.D., Section of Diagnostic Radiology, Mayo Clinic

2:00 p.m. Exhibit Break

2:30 p.m. Film Reading Panel

Robert S. Wright, M.D., St. Francis Hospital, Peoria; Robert Dennis Bahr, M.D., Lake Forest Hospital, and Clinical Instructor of Radiology, Chicago Medical School; and Constantine S. Soter, M.D., Northwest Community Hospital, Arlington Heights

4:15 p.m. Business Meeting—Illinois Chapter, American College of Radiology

5:30-6:30 p.m. Reception

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

Tuesday, May 17 **Gold Room 114**

Chairman: W. T. Liberson, M.D., Hines

1:30 p.m. "Immediate Fitting and Early Ambulation Following Amputation of a Lower Extremity"

Allan S. Russek, M.D., Director, Prosthetic Service, Institute of Physical Medicine and Rehabilitation, New York City

"Early Diagnosis of Cerebral Palsy and Muscular Dystrophy"

Meyer Perlstein, M.D., Head, Children's Neurological Clinic, Cook County Hospital

"Early Management in Pediatric Physical Medicine and Rehabilitation"

Harriet Gillette, M.D., Cleveland Clinic

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Tuesday, May 17 **Ruby Room 113**

Chairman: Arthur G. Baker, M.D., Waukegan

2:00 p.m. Symposium: "Recent Advances in Preventive Medicine"

"What's New in Maternal and Child Health Care"

Helen D. Heinen, M.D., Regional Medical Consultant, Children's Bureau, U. S. Department of Health, Education and Welfare, Chicago

"What's New in Adult Health Promotion"

Mark Lepper, M.D., Professor of Preventive Medicine, University of Illinois College of Medicine

EXHIBIT BREAK

Panel: "Some Experiences in Developing Home Health Care Services"

Robah Kellogg, R.N., Director, Division of Nursing Services, Lake County Health Department and Community Nursing Service of Lake County, Inc., Waukegan

Eunice Kelly, R.N., Director, Division of Nursing Services, DuPage County Health Department and Community Nursing Service of DuPage County, Inc., Wheaton

PATHOLOGY

Tuesday, May 17 **Ruby Room 113**

Chairman: Grover L. Seitzinger, M.D., Danville

6:00 p.m. Dinner and annual business meeting

PAST PRESIDENTS' DINNER

Tuesday, May 17 **Starlight Room**

6:00 p.m.

"A SALUTE TO THE GASLIGHT ERA"

Tuesday, May 17 **Ballroom**

8:30 p.m. Music — Entertainment — Food Fun

*Mickey Sharp—Gaslight Era Host
*Franz Jackson's Dixieland Jazz All-Stars
*Carl Gronemeyer's Dixieland Quintet—Featuring Jan Evans
*Agnes Sampson's Musical Trio
*The Metropolitan Male Quartet
*The Flora Dora Girls

Souvenirs — Favors — Sandwich Bar

BY RESERVATION ONLY

(No banquet this year—but a great party)

SECTION ON EENT

Wednesday, May 18 **Crystal Room**

Chairman: Roland I. Pritikin, M.D., Rockford

8:30 a.m. "Dizziness"—Panel

Moderator: Emanuel M. Skolnik, M.D., Professor of Otolaryngology, University of Illinois College of Medicine

Joseph E. Alfano, M.D., Department of Ophthalmology, Northwestern University Medical School

David F. Austin, M.D., Assistant Professor of Otolaryngology, University of Illinois College of Medicine

George H. Pollock, M.D., Clinical Professor of Psychiatry, University of Illinois College of Medicine

Nicholas Torok, M.D., Associate Professor of Otolaryngology, University of Illinois College of Medicine

Galdino Valvassori, M.D., Associate Professor of Radiology, University of Illinois College of Medicine

Nicholas Wetzel, M.D., Associate Professor of Surgery, Northwestern University Medical School

SECTION ON PATHOLOGY

Wednesday, May 18 — Gold Room 114

Chairman: Grover L. Seitzinger, M.D., Danville

8:30 a.m. "The Use of Frozen Sections in Early Diagnosis"
William O. Russell, M.D., Pathologist, M. D. Anderson Hospital and Tumor Institute of Houston, Texas

9:50 a.m. Exhibit Break

10:35 a.m. "The Handling of Surgical Specimens, Particularly Biopsies"
William O. Russell, M.D.

3:00 p.m. Pathology Slide Seminar—Hektoen Institute
The Illinois Registry of Anatomical Pathology and Hektoen Institute for Medical Research

SECTION ON PEDIATRICS

Wednesday, May 18 — Louis XVI Room

Chairman: James A. Connor, M.D., Hinsdale

8:30 a.m. "PKU Screening Program in Illinois and Evaluation"
Mary Zeldes, M.D., Illinois Department of Public Health

9:00 a.m. "Head Start — Its Statistics and Interpretation"
Irving Abrams, M.D., F.A.A.P., Medical Director, Chicago Public Schools

9:30 a.m. Exhibit Break

10:15 a.m. "Johnny is Flunking"—Panel
Moderator: J. A. Connor, M.D.
Raymond Robertson, M.D., Hinsdale
R. A. Gordon, M.A., Chief Psychologist, Special Education Department, La Grange Area
Benjamin Boshes, M.D., Chairman, Department of Neurology and Psychiatry, Northwestern University Medical School
Lauren Schwisow, Ed.D., Assistant Superintendent for Instruction, Hinsdale Public Schools

SECTION ON DERMATOLOGY

Wednesday, May 18 — Jade Room 103

Chairman: Louis Rubin, M.D., Rockford

9:00 a.m. "Practical Points in Diagnosis and Treatment of Pigmented Lesions"
S. W. Becker, Jr., M.D., Associate Professor of Dermatology, University of Illinois College of Medicine

10:00 a.m. Exhibit Break

10:45 a.m. Panel: "Reactions to Drugs and Cosmetics"
Moderator: Paul Lazar, M.D., Assistant Professor of Dermatology, Northwestern University Medical School

Panelists:

Norman De Nosaquo, M.D., Director, Registry on Adverse Reactions, American Medical Association

Adolph Rostenberg, M.D., Professor and Head of Dermatology, University of Illinois College of Medicine

CAMP MEMORIAL LECTURE

Wednesday, May 18 — Louis XVI Room

2:00 p.m. "The Development of Weapons"
William M. Mebane, Ph.D., Secretary, Thiokol Chemical Corporation

CONTINUED EDUCATION PROGRAM IN PSYCHIATRY FOR PHYSICIANS

Sponsored by the Department of Psychiatry and Neurology of The Chicago Medical School

Wednesday, May 18 — George Bernard Shaw Room

3:00 p.m. Anxiety in Physical Trauma
"Post-traumatic Reactions"
"Traumatic Neurosis"
Roy R. Grinker, M.D., and H. H. Garner, M.D.

Family Crisis
"Depression and Suicide"
"Unwanted and Illegitimate Pregnancy"
"Divorce"
Francis J. Gerty, M.D., and LeRoy P. Levitt, M.D.

6:00 p.m. Dinner

7:15 p.m. Panel: Sexual Morality in the Adolescent
Bernard Block, M.D., Moderator

Rev. James Murtaugh, Director of Catholic Family Consultation Service

Rev. Mark Shapiro, Rabbi, B'Nai Jehoshua Congregation

Rev. Buchner Coe, Pastor, First Congregational Church, Wilmette

Dr. John C. Lee, Director, Residency Training Program at The Chicago Medical School

Dr. Arthur E. Wright, Director, Education and Training, Illinois Youth Commission

Judge Walter P. Dahl, Presiding Judge, Juvenile Court, Chicago

Scientific Exhibits

S-1

Title: **Endocrinologic Aspects of Pregnancy**

Exhibitors: Frederick H. Falls and Charlotte S. Holt

Institution: Illinois State Department of Public Health, Springfield

Description: Pregnancy and parturition are intimately associated and to some extent under the control of the endocrine system. The special relationship of the adrenal, ovary, pituitary, thyroid and pancreas will be presented on separate panels and male and female aspects will be discussed. Lettered charts, drawings, plastic carvings, sculptures and microscopic translights will also be presented.

S-2

Title: **Clinical and Experimental Aspects of Motor Nerve Conduction Velocity**

Exhibitors: D. I. Abramson, L. S. W. Chu, S. Tuck, Jr., S. W. Lee, G. Richardson and M. Levin

Institution: Department of Physical Medicine and Rehabilitation, University of Illinois College of Medicine, Chicago

Description: Graphs, transparencies and photographs are used to emphasize the value of motor nerve conduction velocity studies as a diagnostic tool in carpotunnel syndrome, tarsal-tunnel syndrome, neuropathies, myelopathies and myopathies. The technique of the procedure is demonstrated. Also the effect of experimental alterations in tissue temperatures and in blood flow on nerve conduction velocity is graphically presented. Motor nerve conduction velocity appears to be influenced by changes in tissue temperatures and not in local blood flow.

S-3

Title: **Bone Scanning with 85-Strontium and Its Clinical Applications**

Exhibitors: Rafael M. Garces and Robert A. Carlin

Institutions: Evanston Hospital and Northwestern University, Evanston

Description: This exhibit will consist of transparencies explaining the basic techniques (artist's sketch) and fundamentals of bone scanning with 85-Strontium. Brief summaries of case histories and physical findings of selected cases will be presented. Scans showing the localization of the radioactive material in areas of metastatic disease in patients with positive and negative x-rays for metastases will be shown. The importance of knowing the extent and location of bone metastases in the management of these patients will be emphasized.

S-4

Title: **Arteriography of Renal Diseases**

Exhibitors: Arthur R. Crampton and Howard C. Burkhead

Institutions: Evanston Hospital and Northwestern University, Evanston

Description: This exhibit is primarily an educational display of the value of radiologic studies (primarily arteriography) in the diagnosis of renal diseases (vascular, inflammatory, tumors, etc.). The major emphasis will be on selective renal arteriography as an increasingly popular modality which is often capable of making specific preoperative diagnoses and in some cases play the major role in the frequent problem of when and if surgical intervention is indicated. Use will be made of case material from our experience and correlations will be made with operative and pathologic findings.

S-5

Title: **Ultrasound Diagnosis—Theory and Practice**

Exhibitors: Lothar Hussman, H. W. Kienast and Louis D. Boshes

Institution: University of Illinois, Chicago

Description: This exhibit shows that the physician can apply the diagnostic method of echoencephalography without needing complicated technical training. It presents the method as used primarily for examination of brain structures, but as having also a variety of other diagnostic uses, making it helpful for the physician to understand its basic principles. How diagnostic ultrasound is applied successfully in medical practice is shown and implications for further research are outlined.

S-6

Title: **Socio-Economic Characteristics Related to Selected Health Indices in Chicago and Suburban Cook County**

Exhibitors: Abraham Gelperin, Jean E. Bedger and Eveline E. Jacobs

Institution: Welfare Council of Metropolitan Chicago

Description: Population characteristics, socioeconomic and health variables were categorized for Chicago and suburban Cook County. Data for four years (1960-1963) were used. Visitors test their knowledge by pressing true and false buttons connected to eight questions which light up the correct answer concerning the three major factors which affect each of the following: infant mortality, child mortality, maternal mortality, prematurity and illegitimacy. The factors utilized were median income, per cent nonwhite, education level, per cent substandard housing, per cent mothers under 25 years, occupation category, per cent children living with one or no parent and per cent recent migrants (5 years) from the south.

S-7

Title: **Photochromogenic Mycobacterial Pulmonary Infection in Chicago**

Exhibitors: Y. Takimura, M. R. Lichtenstein and J. R. Thompson

Institution: City of Chicago Municipal Tuberculosis Sanitarium

Description: This exhibit presents in brief outline form the demography, clinical features, bacteriology and pathology of photochromogenic infections. The number of patients with pulmonary disease yielding this organism is steadily increasing and for some unknown reason the majority of the patients reside on the north side of the city.

S-8

Title: **Evaluation of Impairment**

Exhibitors: Frederick A. Stam and Ralph E. DeForest

Institution: American Medical Association, Chicago

Description: The distinction between "impairment" and "disability" is presented. The physician's role in each is considered. A scientific method of impairment rating is demonstrated through an example of a hypertensive stroke patient. The viewer is informed that the American Medical Association has a series of guides for evaluating impairment and is given the opportunity to peruse copies of those presently available.

S-9

Title: **Full-Time County Health Departments in Illinois**

Exhibitor: Harold K. Fuller

Institution: Illinois State-Wide Public Health Committee, Springfield

Description: The exhibit illustrates the basic services of full-time county health departments and describes the possibility of cooperation between the County Medical Society and county health department in providing adequate county health department services.

S-10

Title: **The Rh Sensitized Pregnancy—Diagnosis and Management**

Exhibitors: William M. Alpern, Allan G. Charles and Emanuel A. Friedman

Institution: Michael Reese Hospital, Chicago

Description: This exhibit presents a comprehensive approach to the diagnosis and management of the Rh sensitized pregnancy. The standards of antepartum care are outlined. Timing and technique of amniocentesis are illustrated by photographs and a short film strip. The authors' method of interpreting spectrophotometric analysis of amniotic fluid and its prognostic value is detailed. Intrauterine transfusion of the fetus is illustrated in relation to the materials, methods, complications and results. A dramatic reduction in the perinatal mortality to less than 5 per cent can be expected if the approach presented is utilized.

S-11

Title: **The Care of the Ileostomy**

Exhibitors: Frederick Stenn, Maurice Ettleson and John McNulty

Institution: Ileoptomists, Inc. of Chicago

Description: A description of the function of the Ileoptomist Society and how it helps the physician in the selection of devices for the care of the ileostomy and the patient suffering from the disease for which the ileostomy was done is provided.

S-12

Title: **Menstrual Disorders in Adolescent Girls**

Exhibitor: Lester A. Nathan, Skokie

Description: A discussion of the problem of menstrual disorders in adolescent girls is presented. Dysmenorrhea, premenstrual cramping and tension in adolescent girls are seen frequently by the physician. Too much reliance has been placed on psychotherapy, liberal use of exercise, good diet and the like, recommended in common text books. Pain is the chief complaint and this must be ameliorated promptly if these essential measures are to be of significant help. Thus the use of effective non-narcotic oral analgesics must be the first step in treatment. Reassurance is essential and misconceptions regarding menstruation, usually based on folklore, must be corrected. Since muscle spasm is an important etiologic factor in the pain, use of an effective muscle relaxant combined with the analgesics improves the response significantly.

S-13

Title: **Hematomas of the Small Bowel—Three Etiologies**

Exhibitors: W. T. Meszaros, Franz Gampl and Victor Spiwak

Institution: Illinois Masonic Hospital, Chicago

Description: Hematomas of the small bowel are important since they produce symptoms of acute abdomen. There are three major causes: (1) trauma, (2) anticoagulant therapy, and (3) blood dyscrasias. If one of these etiologic factors is present, the clinician should consider the possibility of a small bowel hematoma. The roentgenologic examination is of great value in confirming the diagnosis. The diagnostic roentgenologic findings are demonstrated with plain roentgenograms and barium studies.

S-14

Title: **The Temporal Bone Banks Program for Ear Research**

Exhibitors: John R. Lindsay and Robert I. Kohut

Institution: University of Chicago

Description: Large colored translites demonstrate recently acquired inner ear pathology from documented cases of deafness and dizziness with special attention drawn to the anatomy of the normal temporal bone. Another panel of translites shows the processing of the bone and the anatomical orientation. Repeating colored slides demonstrate the techniques for removing temporal bones for pathological study.

S-15

Title: **The Surgical Treatment of Stroke**

Exhibitors: Isa Sejdinaj and Richard C. Powers

Institutions: Sherman Hospital and St. Joseph Hospital, Elgin

Description: The exhibit is a review of clinical experience in a private series of cases of treatment surgically of arterio-sclerotic occlusive disease of the carotid arteries. This includes arteriography, surgery and pathologoy.

S-16

Title: **A Post-Operative Aid to the Reduction of Urinary Retention**

Exhibitors: Martin E. Felder, Richard P. Dickey and William Copeland

Institution: Department of Obstetrics and Gynecology, Ohio State University Hospital, Columbus, Ohio

Description: This is a controlled evaluation of therapy with a proteolytic enzyme in the management of urethral edema which is known to follow cystocele repair. It is a double-blind study involving 100 patients, half of whom received streptokinase-streptodornase orally and half of whom received a placebo. The patients in the series receiving the medication were dismissed from the hospital an average of two days earlier than those receiving the placebo. Spontaneous voiding was more frequent in the treated group and the number of additional catheterizations was less.

S-17

Title: **Bio-Assay of Steroids for Topical Application**

Exhibitors: R. B. Stoughton and A. W. McKenzie

Institutions: Cleveland, Ohio and London, England

Description: This exhibit describes the vasoconstrictor effect of various steroids applied to protect and occlude skin. The effect is an indicator of percutaneous absorption and may be useful as an index to determine the topical activity of new compounds. Potency is assessed on a comparative scale.

S-18

Title: **Adjuvant Therapy in Ocular Trauma Sequel**

Exhibitor: Robert H. G. Monninger

Institution: Department of Ophthalmology, Stritch School of Medicine

Description: The exhibit is a basic science and clinical presentation of trauma. Some of the more common types of traumatic eye injuries will be presented in enlarged color photographs. The serial photographs will depict the course and resolution of these traumatic injuries of the orbit and adnexae. Slides and data will further delineate the pathology of trauma to soft tissue. Case presentations by transparencies will be complemented by summaries of etiology and treatment of ocular trauma.

S-19

Title: **BCG and Elimination of Tuberculosis**

Exhibitor: Sol Roy Rosenthal

Institutions: Institution for TB Research, University of Illinois; Cook County Hospital; Chicago Board of Health; and Research Foundation

Description: Four panels depict the conditions under which tuberculosis can be controlled or eliminated. The studies represent some 12,000 infants, children and young adults under varying degrees of exposure to tuberculosis and socio-economic conditions. Approximately one-half of the subjects were BCG vaccinated, the remainder served as controls.

S-20

Title: **Group Practice**

Exhibitor: John A. Rowland

Institutions: American Association of Medical Clinics, American Medical Association and the Medical Group Management Association

Description: Jointly developed by the co-sponsoring associations, this exhibit provides a working definition of group medical practice and measures the increases in total number of groups and group-associated physicians over a 20-year

period. Distribution of groups and group physicians is illustrated on a state-by-state basis. Not intended to either promote or discourage group practice, the exhibit identifies fundamental concepts which should be considered by the physician contemplating affiliation with an established group or participating in organization of a new medical group.

S-21

Title: **Doctor, You Can Help Control Cancer**

Exhibitors: Caesar Portes, James D. Majarakis and Angelo P. Creticos

Institution: Cancer Prevention Center, Chicago

Description: This exhibit appeals to the practicing physician to help control cancer by examining his well patients in his office. It depicts the medical findings of the Center over the past 5-6 years in statistical form and outlines the entire examination procedure as practiced at the Center. Lastly, it appeals to physicians to send their reports to the Center on patients examined there. Interesting transparencies of carcinoma are also shown.

S-22

Title: **Anatomic Basis for Anorectal Disease**

Exhibitor: George Shropshear

Institution: Provident Hospital, Chicago

Description: A histologic study of the anorectal sphincter mechanism revealing its eight component muscles and the interstitial space, the "anal intermuscular interstice," the gateway to the perianal region and the ischioanal fossa. The clinical significance of the anorectal sphincter is related to the distribution of its longitudinal fibers because of their role in anorectal suppurative disease, in the spread of anorectal malignancy and in the development of hemorrhoids, as well as postoperative anal incontinence.

S-23

Title: **An Understanding of Pain and Its Measurement**

Exhibitor: Eric C. Kast

Institution: Chicago Medical School

Description: The flexion reflex and crossed extensor reflex provides the neurophysiologic basis for an understanding of the pain process. Current ways to measure pain are discussed. A new method, comparing measurable experimental pain with simultaneous pain is presented. In a discussion of the treatment of pain, the analgesic qualities of methotrimeprazine, as measured by the comparative method, are presented.

S-24

Title: **Coracoid Transfer for Recurrent Dislocations of the Shoulder—Modified Bristow Procedure**

Exhibitors: Howard J. Sweeney, Newton D. Mead and Harold D. Thomason

Institutions: Department of Orthopedic Surgery, Northwestern University; and Division of Orthopedic Surgery, Evanston Hospital

Description: The exhibit represents the experiences of 26 consecutive cases of recurrent dislocation of the shoulder in which the modified Bristow procedure has been used. This procedure involves transferring the distal one-half inch of coracoid process with the attached short head of the biceps and coracobrachialis muscles. The coracoid process is transplanted through the subscapularis muscle into the anterior inferior edge of the glenoid of the scapula and fastened in place with a screw. Twenty-three of the 26 patients have been followed with personal examination during the month of December, 1965. It is known that 25 out of 26 patients that we could contact have had no dislocations since surgery. The remaining one patient has disappeared from our source of contacts. The longest follow-up is six years; the shortest is under one year. The majority are two years or

over. There have been no postoperative dislocations; there were no serious complications. In general the range of motion has remained extremely adequate in the majority of cases. Statistics are presented as to the range of motion of external rotation and abduction.

S-25

Title: **Radiocardiograms in Valvular Heart Disease**

Exhibitors: Louis Head, Kenneth Campione, Irene Anday and Jolanta Munch

Institutions: Chicago Wesley Memorial Hospital and Northwestern University

Description: This exhibit describes the usefulness of radiocardiograms (cardiac output by I-131 precordial counting) in the pre- and postoperative management of patients with valvular heart disease. This technique has proved to be a simple method of obtaining quantitative information on heart function without the need for catheterization.

S-26

Title: **Historical Synopsis of American Radiology**

Exhibitor: E. R. N. Grigg

Institution: Cook County Hospital Radiation Center

Description: Illustrations of the men and machines that contributed to the development of American radiology will be presented. These will be divided into three stages: the era of the roentgen pioneers, the golden age of radiology and the atomic phase.

Technical Exhibitors

Company	Booth
Abbott Laboratories	T-52
Americana Corporation	T- 5
Arnar-Stone Laboratories, Inc.	T-47
Astra Pharmaceutical Products, Inc.	T- 7
Ayerst Laboratories	T-12
Berkeley Medical Instruments	T-58
Beutlich, Inc.	T-55
Blue Shield Illinois Medical Service	T-38
Business Products Sales, Inc.	T-28
Carnation Company	T-44
Ciba Pharmaceutical Company	T-42
The Coca-Cola Company	T-13
Contour Chairs Co.	T-62
Daniels Surgical & Medical Supplies	T-1, T-2 and T- 3
Dictaphone Corporation	T- 8
Encyclopaedia Britannica	T-39
Flint Laboratories	T-45
Geigy Pharmaceuticals	T-43
Hertz Rent-All	T-35
Investors Diversified Services, Inc.	T-36
Lederle Laboratories	T-23
Eli Lilly and Company	T-37
Mead Johnson Laboratories	T-48
Medco Products Company	T-31
Medical Business Consultants	T-54
The Medical Protective Co.	T-56
Merck Sharp & Dohme	T-14
The Wm. S. Merrell Company	T-26
Miller Pharmacal Company	T-41
The National Drug Company	T-30
Northern Trust Company	T-33 and T-34
Pacific Medical Equipment Co.	T-25
Parke, Davis & Co.	T-51
Parker, Aleshire & Co.	T-57
Pepsi-Cola General Bottlers, Inc.	T-53
Pfizer Laboratories	T-49
Pictorial Americana	T-21
PM—Professional Management	T-40
Professional Life and Casualty	T-63
J. B. Roerig and Company	T-46
Sandoz Pharmaceuticals	T-24
W. B. Saunders Company	T-59
7-Up Developers Association	T-27
G. D. Searle & Co.	T-61
Smith Kline & French Laboratories	T-50
Smith, Miller & Patch, Inc.	T-22
E. R. Squibb & Sons	T-60
Tar Gard	T-11
U. S. Vitamin & Pharmaceutical Corp.	T- 6
Wallace Laboratories	T-29
Winthrop Laboratories	T- 4

Technical Exhibitors

Booths T-1, T-2 and T-3
DANIELS SURGICAL & MEDICAL SUPPLIES

DANIELS—with Mid-America's Most Ultra Modern Facilities to serve your Modern Professional Needs will again feature the newest in "TOP LINE BRAND" equipment and supplies.

See our individual Model Office Displays—also consult with our Planning, Decorating, Financing, and Service Department at our exhibit.

NEW ITEMS TO BE SHOWN—L-F Uniflex Diathermy—CASTLE'S #7 Speedclave—RITTER's #45 Examining Table—RITTER's "75" Universal Table with full range 12-Positions Automatic Flexibility. HAMILTON'S New Electrically Operated Table—HAMILTON Modular Furniture—Illuminated Eye Chart — TRI-TONE Audiometer — HUDSON Oxygen Unit—SORENSEN Suction Pump—Electronic Stethoscope — WELCH ALLYN Electrically illuminated diagnostic instruments and the Newest in DISPOSABLE PRODUCTS. Descriptive Literature Is Available On All Products.

Booth T-4
WINTHROP LABORATORIES

You are cordially invited to visit the Winthrop booth #4 where representatives will be pleased to give you information on our latest developments in the field of medicine. The exhibit features NegGram (brand of nalidixic acid).

Booth T-5
AMERICANA CORPORATION

See our newly revised 1966 encyclopedia and Min/Max teaching machine.

Booth T-6
U.S. VITAMIN AND PHARMACEUTICAL CORPORATION

Booth T-7
ASTRA PHARMACEUTICAL PRODUCTS, INC.

Information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (propitocaine) local and topical anesthetics; and iron preparations Astrafer® (dextriferron) for intravenous use and Jectofer® (iron sorbitex) for intramuscular administration will be available at the Astra booth.

Booth T-8
DICTAPHONE CORPORATION

For the busy doctor Dictaphone presents the latest in office dictation and portable recording systems. Among physicians, the Time-Master dictating machine with inbuilt telephone recording is most popular together with the ultra-portable, battery-powered Travel-Master. Both use the exclusive Dictabelt record with sound you can see.

For the busy hospital, Dictaphone features the Telecord system for network dictation by phone. Ideal for speedy, accurate medical record-keeping, the Telecord also uses the Dictabelt record.

A new Autopsy dictation station, featuring hand-and-foot-free operation via electric eye will be of special interest to pathologists.

Booth T-11
TAR GARD COMPANY

Tar Gard is a patented filter-holder device, based on the Venturi principle, for trapping tars from cigarette smoke. At the meeting, the efficiency of this unit will be demonstrated by means of a smoking machine (complete with Tar Gard and filter cigarette) set to simulate an average smoking pattern. Physicians attending this exhibit will be able to witness for themselves, tars actually being extracted from cigarette smoke.

Booth T-12
AYERST LABORATORIES

Ayerst Laboratories extends an invitation to visit our exhibit located in booth #12 where "Penbritin" is featured. Our representatives will be pleased to discuss this or other Ayerst products with you.

Booth T-13
THE COCA-COLA COMPANY

Booth T-14
MERCK SHARP & DOHME

The Merck Sharp & Dohme exhibit has been designed to supplement the physician's therapeutic armamentarium. Technically trained personnel are present to discuss the scope and variety of services offered.

Booth T-20
HEWLETT-PACKARD/Crossley Sales Division

Sanborn Division, Hewlett-Packard Company, Waltham, Massachusetts will exhibit

the latest in Intensive Care Instrumentation including monitoring scopes, ECG recorders, D. C. Defibrillator, and other units of modular interchangeable construction for incorporation into a complete Intensive Care Monitoring System. Representatives will be pleased to discuss technical problems relating to specifications, operation, and installation requirements.

Booth T-21
PICTORIAL AMERICANA

Booth T-22
SMITH, MILLER & PATCH, INC.

Smith, Miller & Patch, Inc. cordially invites you to visit their exhibit. Our representatives will be pleased to discuss the latest advances in therapy. Featured at our exhibit will be: Cephalgesic, a new product for the treatment of headache; Lipoflavonoid, Lipotriad, Vitron-C and Kondremul. Also featured will be a wide range of topical ophthalmic preparations, including Vasocon-A, an antihistamine/decongestant.

Booth T-23
LEDERLE LABORATORIES

Lederle Laboratories, one of the leaders in medical research and development, is proud to support the 126th Annual Convention of the Illinois State Medical Society. Our sales representatives are qualified to discuss products such as DECLOMYCIN®, ACHROMYCIN®V, ARISTOCORT®, AMICAR®, as well as our many services to physicians. We hope to be of service to your practice.

Booth T-24
SANDOZ PHARMACEUTICALS

Sandoz Pharmaceuticals cordially invites you to visit our display at booth #24 where we are featuring Mellaril, Sansert, Cafergot P-B, Fiorinal and Fiorinal with codeine.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

Booth T-25
AUDIO-DIGEST FOUNDATION

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique, these medical tape-recorded services are now offered in seven series: General Practice, Surgery, Internal Medicine, Obstetrics and Gynecology, Anesthesiology and Ophthalmology.

Digest subscribers listen in their car, home or office. Carefully selected tape equipment for playing the digests is offered at the convention by Pacific Medical Equipment Co.

Booth T-26
THE WM. S. MERRELL COMPANY

Merrellmen always have an up-to-date status report on Merrell's significant prescription products. They will be happy to convey latest clinical reports to you in summary form when you visit the Merrell booth.

Booth T-27
7-UP DEVELOPERS ASSOCIATION

The organizations that bottle and deliver sparkling, crystal-clear 7-Up and LIKE to the people of Illinois will be represented at booth #27. They will be ready at all times to provide the fresh, clean taste of chilled 7-Up or LIKE for thirsty conventioneers. Nothing does it like 7-Up!

Booth T-28
BUSINESS PRODUCTS SALES, INC.

Business Products Sales, Inc. has a unique answer to monthly billing. This system eliminates errors, cuts billing time to practically nothing with individual statements completely addressed and itemized. The "Q System" is simple, electrical and economical.

The new 3M "Cantata 700" Background Music System enables you to have highest quality music at low cost. This totally new approach to the music system will be a fine addition to your office or clinic.

Booth T-29
WALLACE LABORATORIES

We invite you to visit our booth where our representatives in attendance will be pleased to furnish information regarding Wallace products and your related medical questions to assist you in your practice. Featured is our product "Miltown" and other drugs of original research.

Booth T-30
THE NATIONAL DRUG COMPANY

The National Drug Company will exhibit new AVC DIENESTROL for atrophic vaginitis complicated by infection. TEPANIL TEN-TAB (diethylpropion hydrochloride continuous release form) indicated for day-long reduction of appetite as an aid in any weight reduction program, even for diabetics, hypertensives and cardiacs; ORENZYME, the original oral proteolytic enzyme for reduction of inflammation and edema; and AVC IMPROVED for comprehensive vaginal anti-infective therapy.

Booth T-31
MEDCO PRODUCTS COMPANY, INC.

Medco's direct reading INSTANT Thyroid test. The Medco ACHILLEOMETER is a solid state (transistorized) Achilles Reflex Test (A.R.T.) computer. Permits immediate and accurate diagnosis, answers the problem of the borderline and Hypo-Thyroid and response to therapy. As no electrocardiograph is necessary, the ACHILLEOMETER offers the Achilles Reflex Test (A.R.T.) method of testing thyroid function to many additional physicians. Compact (5½ lbs.), no warm-up period, desk-top convenience.

Booth T-32
THE UPJOHN COMPANY

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you, products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Booth T-33 and T-34
THE NORTHERN TRUST COMPANY

The Electronic Billing and Bookkeeping Service available to the medical profession at The Northern Trust Company is featured at the Bank's booth. This service, for individual physicians and clinics, provides fast, accurate uniform record keeping at low cost. It saves money, helps improve collections through on-time billing, facilitates follow-up control over the delinquencies and provides summary reports of all activities.

The exhibit explains how the service works. Bank personnel will be on hand to answer questions.

Booth T-35
HERTZ RENT-ALL

Booth T-36
INVESTORS DIVERSIFIED SERVICES, INC.

Investors Diversified Services, Inc., with its subsidiary and affiliated companies, frequently referred to as the Investors Group, is unique among the nation's leading financial institutions. It is the largest investment corporation of its kind in the world—having currently more than $5.3 billion in assets under management, and in excess of one million customer accounts. From its beginning in 1894, the company has maintained its own sales organization for the purpose of offering its securities directly to the public. The sales force now numbers approximately 3,500 field representatives working out of 165 divisional offices in the United States, and distributing only the securities and insurance of Investors Group companies.

Booth T-37
ELI LILLY AND COMPANY

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance welcome your questions about Lilly products. You may be particularly interested in discussing KEFLIN® Cephalothin or C-QUENS™ Sequential folder containing fifteen 80 mcg. tablets of mestranol plus five tablets each combining 80 mcg. mestranol and 2 mg. chlormadinone acetate.

Booth T-38
BLUE CROSS—BLUE SHIELD

Booth T-39
ENCYCLOPAEDIA BRITANNICA

Encyclopaedia Britannica welcomes delegates to the 126th Annual Convention of the Illinois State Medical Society and invites them to examine the great new edition of Britannica.

Official delegates may now purchase this magnificent set at an offer only available at our convention exhibits. Visit Britannica's Booth #39 for free descriptive literature.

Booth T-40
PM—ILLINOIS PROFESSIONAL MANAGEMENT

The PM GROUP provides a complete business service for the medical profession. The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of the oldest and largest such firm in the country are at their command.

Those in attendance at the Illinois State Medical Society Convention are cordially invited to stop and meet the experienced PM executives there.

Booth T-41
MILLER PHARMACAL COMPANY

Products designed to support the extra requirements of the body's hundreds of enzyme systems for minerals, vitamins and amino acids during periods of stress and subnormal nutrition. Because of their satisfaction in prophylaxis and therapy, patients appreciate these truly scientific preparations: CARDENZ, CHENATAL, Fe-PLUS, HYALEX, LYSMINS, Mg-PLUS, NUCLOMINS, Mg-C, RAGUS SCLEREX, ULCIMINS and DENOL for emergency ulcer therapy.

Booth T-42
CIBA PHARMACEUTICAL COMPANY

Booth T-43
GEIGY PHARMACEUTICALS

Geigy Pharmaceuticals cordially invites members and guests of the Society to visit its exhibit. The exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

Booth T-44
CARNATION COMPANY

Carnation Company cordially invites you to visit booth #44, where medical representatives will be pleased to welcome members and guests of the Illinois State Medical Society. Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat, Carnation Instant Breakfast and Carnalac new formula are available.

Any questions pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

Booth T-45
FLINT LABORATORIES

Featured products are SYNTHROID® and HU-TET™ . . . SYNTHROID (sodium levothyroxine) Tablets and Injection, the active principle of the thyroid gland, prepared synthetically in pure crystalline form for predictable and stable therapeutic results.

HU-TET (Tetanus Immune Globulin-Human), tetanus antitoxin of human origin for virtual freedom from sensitivity reactions. Now available from FLINT LABORATORIES in 250 unit vials for economical and long-lasting protection.

Booth T-46
J. B. ROERIG & COMPANY

J. B. Roerig & Company will welcome members of the medical profession at the company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you.

Booth T-47
ARNAR STONE LABORATORIES, INC.

AMERICAINE TOPICAL ANESTHETIC —20% dissolved benzocaine in a water-soluble base—ointment, liquid, suppositories and aerosol forms. Aerosol operates rightside up or upside down for contortion-free application. METALEX—anabolic, respiratory and circulatory stimulant—Vasodilator combination for treatment of symptoms of advancing age and certain auditory and visual defects. TETRASULE—prolonged protection against attacks of angina pectoris—b.i.d. dosage of PETN with or without sedation.

Booth T-48
MEAD JOHNSON LABORATORIES

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Booth T-49
PFIZER LABORATORIES

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information.

To make your visit worthwhile, technically trained medical service representatives will be on hand to discuss with you the latest developments in Pfizer research.

Booth T-50
SMITH KLINE & FRENCH LABORATORIES

Representatives will be on hand to answer your specific questions and provide information on their products and services.

Booth T-51
PARKE, DAVIS & COMPANY

Medical service members of our staff are in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Booth T-52
ABBOTT LABORATORIES

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

Booth T-53
PEPSI-COLA GENERAL BOTTLERS, INC.

"You're in the Pepsi generation."

Stop at the Pepsi booth and have a refresh-

ing drink with us. We like to drink with our friends. Pat & Bob.

Booth T-54
MEDICAL BUSINESS CONSULTANTS

You may be surprised at the unusual savings available to you. Savings in your time, taxes and office costs are secured through analysis and recommendation on a monthly or single occasion basis. We'll be happy to explain how your colleagues are conserving more of their earnings through specialized management, financial and tax planning.

Booth T-55
BEUTLICH, INC.

Beutlich, Inc. will feature Peridin-C, for the non-hormonal control of the menopausal hot flash; Mandalay, the new dual layered methenamine mandelate tablet; and CEO-TWO, the carbon dioxide enema-like suppository. A rapid (20 seconds) and simple ascorbic acid test will be demonstrated to those who are interested.

Booth T-56
THE MEDICAL PROTECTIVE COMPANY

With exceptional proficiency in defense, so essential to the doctor's protection today, the Medical Protective Company offers unexcelled coverage in any claim or suit for damages based on professional services rendered or which should have been rendered. Its experience, from the successful handling of 90,000 claims and suits during 67 years of professional protection exclusively, is unparalleled in the professional liability field.

Booth T-57
PARKER, ALESHIRE & COMPANY

As the administrators of the officially sponsored Group Disability Plan and Group Major Medical Plan for members of the Illinois State Medical Society, we invite you to drop by our booth and discuss these fine programs with our representatives.

Both plans provide broad coverages that cannot be duplicated under an individual policy at a comparable premium cost to you. Review *your* group insurance NEEDS TODAY!

These programs are another benefit of your membership in the Illinois State Medical Society and deserve your consideration.

Booth T-58
BERKELEY MEDICAL INSTRUMENTS

A new and simplified method for accurate Hemoglobin, Glucose, Uric acid, Cholesterol and B.U.N. determinations in the doctor's office or in the laboratory. Highly reliable results available in minutes. Pre-calibrated, simplified procedures. Very inexpensive operations. The instrument is compact, rugged and completely transistorized. These units are in regular use in doctors' offices, laboratories, medical schools and hospitals.

Booth T-59
W. B. SAUNDERS COMPANY

New Saunders books of clinical interest published since last year's meeting include: Ingelfinger, Relman and Finland: "Controversy in Internal Medicine," Lamb: "E.K.G.," Bockus: "Gastroenterology, Vol. III," Schaffer: "Diseases of the Newborn," Nealon: "Management of the Patient with Cancer," Gellis and Kagan: "Pediatric Current Therapy," Greenhill: "Obstetrics" and Conn: "Current Therapy 1966."

Booth T-60
E. R. SQUIBB & SONS

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed.

At booth #60, we will be pleased to present up-to-date information on these advances for your consideration.

Booth T-61
G. D. SEARLE & COMPANY

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle products of research.

Featured will be Enovid for ovulation control and pregnancy and menstrual disturbances and Flagyl, a potent, new trichomonacidal agent for trichomonal vaginitis, cervicitis, urethritis and prostatitis.

Booth T-62
CONTOUR CHAIRS

Booth T-63
PROFESSIONAL LIFE AND CASUALTY COMPANY

Representatives of the company will be in attendance during the entire meeting to discuss the plans of insurance available to members of the medical profession. Of particular interest are the TERM LIFE and the new PARTICIPATING WHOLE LIFE Insurance Plans, both receiving nationwide acceptance. These Plans provide a fine addition to the professional man's insurance portfolio—allowing for a high amount of life insurance benefits at low net cost.

SCIENTIFIC MOTION PICTURE PROGRAM

Scientific movies will be shown continuously Monday through Wednesday, from 9:00 a.m. to 4:30 p.m.

9:00 to 9:32

CLINICAL ENTITIES, CUSHING'S DISEASE.

Color, sound, 32 minutes.

Prepared by Peter H. Forsham, M.D., San Francisco.

Patients having Cushing's Disease are compared with patients who are simply obese. After demonstrating the characteristic differences in fat distribution, the film clearly describes the causes and patho-physiology of Cushing's Disease with the aid of animation and patients with the disease. The rational treatment for each aspect of the disease is described.

9:34 to 10:08

CHRONIC BRONCHITIS AND EMPHYSEMA.

Color, sound, 34 minutes.

Prepared by John B. Hickam, M.D., Indianapolis.

This film presents the clinical entity embodied by pulmonary emphysema and chronic bronchitis. The basic pathological anatomy and physiology are presented. The film also discusses diagnosis and treatment and includes patients in various stages and variations of the entity.

10:10 to 10:30

WHY BLOOD VOLUME?

Color, sound, 20 minutes.

Only recently have techniques been so improved and simplified that rapid, accurate blood volume determinations can be made routinely. Because of this new ease with which blood volume can be measured, this film examines more closely the indications for such measurement and the value derived from them.

10:32 to 10:57

TRACHEOTOMY.

Color, sound, 25 minutes.

Prepared by C. Jan Beekhuis, M.D., Detroit.

This film describes the surgical anatomy involved in a tracheotomy, first by diagrams and then in a step-by-step fashion on a cadaver. Following this, a tracheotomy is demonstrated on a live patient, stressing the technique of the procedure and how complications can be avoided.

10:59 to 11:23

LIGATION OF THE INTERNAL ILIAC (HYPOGASTRIC) ARTERIES: A LIFE-SAVING PROCEDURE FOR UNCONTROLLABLE GYNECOLOGIC AND OBSTETRIC HEMORRHAGE.

Color, sound, 24 minutes.

Prepared by Mitchell J. Nechtow, M.D. and Walter J. Reich, M.D., Chicago.

The movie presents a discussion of the anatomy, beautiful demonstrations of cadaver anatomy and actual surgical demonstrations in the operating room.

11:25 to 11:42

A NEW LOOK AT TETANUS PROPHYLAXIS.

Color, sound, 17 minutes.

Prepared by Wesley Furste, M.D., Columbus, Ohio.

This film begins with a statement of the comparatively poor current status of tetanus immunity in the United States and indicates the availability of tetanus toxoid, an entirely different effective immunization agent. A four-point medical program which is recommended to physicians for the elimination of tetanus and the side effects associated with certain agents used in prophylaxis is presented.

NOON BREAK

2:00 to 2:32

CLINICAL ENTITIES, HYPERTENSION OF ADRENAL ORIGIN: ALDOSTERONISM AND PHEOCHROMOCYTOMA.

Color, sound, 32 minutes.

Prepared by Peter H. Forsham, M.D., San Francisco.

These two different disorders of the adrenal glands are of vital importance because if they are diagnosed early, the hypertension caused by them can be cured. In the film, patients with these clinical entities describe their symptomatology. These symptoms are related to the underlying pathology of the disease entity and to the diagnosis. The approach is geared to the working tools available to the practitioner of medicine, particularly the history and physical examination. The electrolyte changes which occur in each entity are described and the hormonal defects are presented through animation techniques.

2:34 to 3:04

MODERN MANAGEMENT OF PREGNANCY IN THE Rh NEGATIVE SENSITIZED WOMAN.

Color, sound, 30 minutes.

Prepared by Allan Charles, M.D., and Wm. Alpern, M.D., Chicago.

This film presents a practical manual of the latest techniques and procedures for management of the pregnancy of the Rh negative sensitized woman.

3:06 to 3:37

I'VE BEEN LIVING WITH GOUT.

Color, sound, 31 minutes.

Prepared by L. Maxwell Lockie, M.D. and Bernard M. Norcross, M.D., Buffalo, New York.

This film shows how prophylactic therapy has become accepted as a routine part of a patient's life and how it enables him to function in daily activities.

3:39 to 4:06

PLASTER CASTS AND SPLINTS: PREPARATION, APPLICATION, REMOVAL.

Color, sound, 27 minutes.

Prepared by the American Academy of Orthopedic Surgeons, Chicago.

After a brief history of splints and the development of plaster of Paris, some of the problems in its use are stated and illustrated. How these problems may be met is delineated through demonstrations. The principles for immobilization of joints are illustrated by diagrams and several other types of casts and splints are depicted. A variety of recommended methods of removal of casts is presented.



the
126th CONVENTION
of the
ILLINOIS STATE MEDICAL SOCIETY
presents on
MAY 17, 1966
a . . .

SALUTE to the GASLIGHT ERA



Our Cast Includes . . .

Mickey Sharp, a pint-sized comic who headlined all the way from Miami Beach to the swank supper clubs of Las Vegas, delighting audiences with his comments on current events and political personalities.

Carl Gronemeyer's Dixieland Quintent: these Gaslight Club regulars feature pretty Jan Evans along with some of Chicago's most famous Dixieland jazz.

Franz Jackson's Dixieland Jazz All-Stars shine as the feature attraction at the ISMS "Salute to the Gaslight Era." Franz learned to play the clarinet as a little boy and played with many of the famous Negro bands of the twenties. He is now a "name" musician in his own right and has made many concert appearances throughout the United States.

Agnes Sampson's Trio adds the feminine touch to the night's festivities. The musical group will table hop, singing and playing favorite songs on request.

The Metropolitan Male Quartet: in the style of the turn of the century, close harmony renditions of such old favorites as "East Side, West Side" and "My Gal Sal" will again resound. You're invited to sing along.

Extra Added Attraction . . .

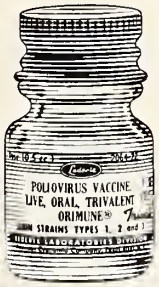
The Flora Dora Girls, demonstrating the Charleston, the Bunny Hug and all the dances from the 1900's to the "go-go" era. Learn a new dance step or practice an old one with the lovely Flora Dora Girls.

Also Included . . .

Sandwich Bar, Souvenirs and Favors, Good Food and Fine Beverages all served in the colorful atmosphere of the Sherman House Grand Ballroom at 8:30 p.m., Tuesday, May 17.

WATCH THE MAIL FOR YOUR RESERVATION!

Doctor...two important Lederle products for routine office procedures



single-dose vials for convenient and economical polio immunization

ORIMUNE®

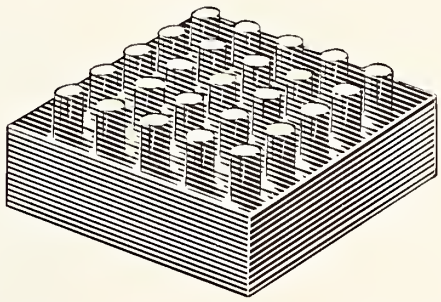
POLIOVIRUS VACCINE, LIVE, ORAL

TRIVALENT

SABIN STRAINS, TYPES 1, 2 and 3

Fast, simple administration—and economy for the patient—make the new 0.5 cc single-dose vial of ORIMUNE Trivalent ideal for private practice. (Packaged 5 to a box with 5 sterilized disposable droppers for your convenience).
(Also available in 2 cc and 2 drop dosage forms).
Only 2 doses required for complete, initial immunization for patients more than a year old.

Effectiveness—may be expected to confer active immunity against all three types of poliovirus infection in at least ninety percent of susceptibles only if given at full dosage, as directed. No characteristic side effects have been reported. There are, however, certain contraindications. These are, broadly: acute illness, conditions which may adversely affect immune response, and advanced debilitated states. In these, vaccination should be postponed until after recovery.
In infants vaccination should not be commenced before the sixth week of life. Do not give to patients with viral disease, or if there is persistent diarrhea or vomiting. ORIMUNE and live virus measles vaccine should be given separately.
Dosage—initial immunization: two doses each given orally at least 8 weeks apart. (Give a third dose to infants at 10-12 months). Booster immunization: one dose, given orally. See package literature for full directions.



simplifies routine screening

TUBERCULIN, TINE TEST

(Rosenthal) Lederle

Swab • Uncap • Press • Discard

Comparable in accuracy and reliability to older standard intradermal tests*, but faster and easier to use. Since TINE TEST is relatively painless it should receive greater patient acceptance. Results are read at 48-72 hours. The self-contained, completely disposable unit requires no refrigeration and is stable for two years.
Side effects are possible but rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. Available in boxes of 5 (new individually-capped unit); cartons of 25.

*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York
605-6-3390

Lederle

FREE LITERATURE AVAILABLE TO MEMBERS

The various departments of the Illinois State Medical Society are offering interesting and informative literature to the membership, free of charge. Fill in the coupon below with the quantity desired on the line following the numbers.

1. Dr. Sims Guide to Voluntary Health Agencies
2. Home From the Hospital
3. Physicians' Placement Brochure
4. Students' Medical Loan Fund
5. Profile of Dr. Sims
6. Disaster Manual for Hospitals
7. Rx For a Good Meeting
8. Scientific Speakers Bureau Roster (for County Society meetings only)
9. Know Your Politics
10. How the Opinion Maker Makes Opinion
11. AMPAC's Political Education Series: "Know Your Community"; "Political Party Structure"; "The Precinct Organization"; "Working Within the Party"; "The Medical PAC Structure"; "The Candidate Support Committee"; "The Political Campaign"; and "Politics with the Woman in Mind."
12. Drug Abuse: The Empty Life
13. Prescribing and Dispensing of Narcotics Under Harrison Narcotic Law
14. Narcotics Addiction: Official Action of the American Medical Association
15. First Facts About Drugs
16. Narcotic Drug Addiction
17. Rehabilitation in Drug Addiction
18. Facts About Narcotic Drug Addiction
19. Prevention and Control of Narcotic Addiction.
20. The Official Position of the U.S. Bureau of Narcotics on Handling Narcotic Addicts
21. Interprofessional Code for Physicians and Lawyers of Illinois

1.———	8.———	15.———
2.———	9.———	16.———
3.———	10.———	17.———
4.———	11.———	18.———
5.———	12.———	19.———
6.———	13.———	20.———
7.———	14.———	21.———

Mail to:

Illinois Medical Journal
360 North Michigan Avenue
Chicago, Illinois 60601

NAME _____

ADDRESS _____

CITY_____ STATE_____ ZONE_____

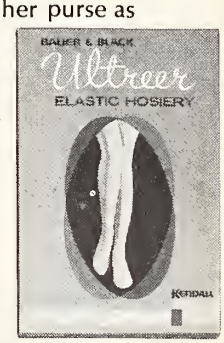
You prescribe elastic stockings. She won't wear them. Now what?

Ultreer™

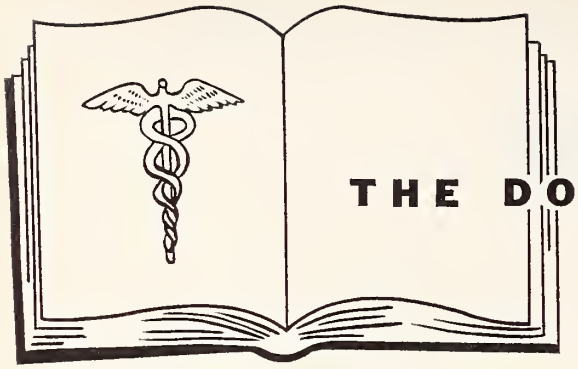


Elastic Stockings so sheer they look like support hose. Both Ultreer and support hose are sheer, shapely, cool and comfortable. But that's where the similarities end. New Ultreer fits firmly and evenly over the entire leg. Gives true therapeutic compression necessary to relieve varicose veins and other leg disorders. They provide the therapy you prescribe. The fashion and economy she demands.

Ultreer stockings have a new low price. So low, she can afford two pairs of Ultreer instead of one pair of regular elastic stockings. There'll be no disagreements there. Ultreer stockings are as comforting to her purse as they are to her legs. New Ultreer are the elastic stockings doctors and women can agree on.



KENDALL
BAUER & BLACK SUPPORTS DIVISION



THE DOCTOR'S LIBRARY

INTESTINAL ABSORPTION. T. Hastings Wilson, M.D. W. B. Saunders, Philadelphia, 1965, pp. 263.

The author has compiled a large amount of important information relative to the digestive tract and its function in a concise and readable manner. There is an excellent initial chapter which describes the morphology of the gut, followed by a brief review of the methods used in the study of intestinal absorption. Subsequent chapters are devoted to detailed discussions of data related to the mechanisms of digestion and absorption of sugars, amino acids, fluids and electrolytes, triglycerides, cholesterol, bile salts and phospholipids, large protein molecules, vitamins and certain drugs. Each chapter is followed by an extensive reference list.

The book contains an enormous amount of experimental and clinical evidence regarding the mechanisms of intestinal absorption, and will be of value and interest to everyone interested in the function and dysfunction of the gastrointestinal tract.

M. C. Anderson, M.D.

MANAGEMENT OF THE PATIENT WITH CANCER. Thomas F. Nealon, Jr. with contributions by 71 authorities, 1067 pages. W. B. Saunders Company, Philadelphia, 1965. $27.50.

Doctor Nealon has filled a great need in providing a complete and current textbook on the many-sided question of how to manage the cancer patient. The contributing authors are an eclectic group that represent both university centers and the major cancer hospitals. Furthermore, the authors represent diverse disciplines. This permits a comprehensive discussion of therapy whether it be surgery, irradiation, or chemotherapy.

The inadequacies of the standard textbooks of medicine and surgery in the area of cancer have been unavoidable. Cancer is not the major interest of the author or editor of such a standard text. The textbooks are organized about the clinical specialties rather than about a disease process which transcends specialty boundaries.

The purpose of the book, as stated by Dr. Nealon in the preface, is "to make available to the general practitioner, internist and general surgeon the essential information concerning cancer of all sites in a sufficiently succinct manner that they can appreciate the best approach to the management of an individual." Dr. Nealon has been singularly successful in reaching this goal. The absence of such a book has always made it difficult to teach oncology to the medical student. The uniform excellence of the essayists and the extensive bibliographies at the end of each topic will greatly expedite this problem. As with any textbook, time may dim its shining, current completeness.

The discussion of Lymphangiography, Head and Neck Surgery, The Breast, were particularly outstanding to this reviewer. The current indications for lymphangiography and its potential as a diagnostic and therapeutic aid are presented with clarity and excellent illustrations. The author is Dr. Wallace who has made many basic contributions to the technique of lymphangiography, as it is now accomplished. Dr. Frazell and two colleagues from Memorial Center have compiled a masterful review of the diagnosis and treatment of head and neck cancer. The enormous clinical experience of these authors and well tabulated statistics are clearly and succinctly presented. Dr. MacDonald's essay on carcinoma of the breast incorporated the attitudes of the complete therapeutic nihilist to the "super radical" resectionist. His conclusion that "the classic radical mastectomy remains the most important therapeutic attack on the disease" is only a detailed analysis of other apologists. In evaluating therapeutic innovations over the past twenty years he concludes "only internal mammary node dissection and chemotherapy adjuvant to radical mastectomy may have future value."

As of this writing, it appears as a "must have" book for the practitioner or student of oncology.

Paul H. O'Brien, M.D.

DISEASES OF THE NEWBORN, second edition. Alexander J. Schaffer, M.D.

The new edition is enlarged and revised. Omissions have been filled in, and where needed, managements of some disorders have been updated.

Physicians, residents and students will find this a valuable reference volume.

L. Martin Hardy, M.D.

to help relieve pain
in common
anorectal disorders

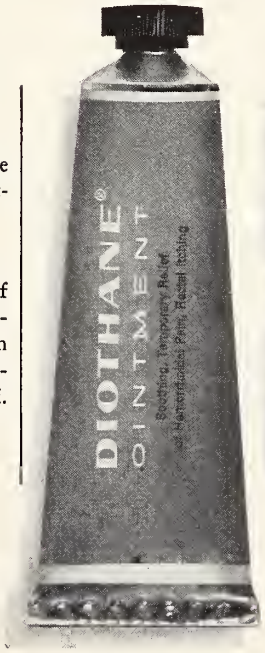
"non-caine"
Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form... both are now available.

'HANE OINTMENT

POSITION:
odon 1.0%; oxyquinoline
ate 0.1% in a special oint-
base.

CATIONS:
les temporary palliation of
hat may result from hemor-
ctomy and from common
tal disorders such as hemor-
anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215/Weston, Ontario

NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen*

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

New Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Consisting of two or more active ingredients.

DUPLICATE SINGLE PRODUCTS

OMNIPEN: Antibiotics-Penicillin ℞

Manufacturer: Wyeth Laboratories, Inc.

Composition: Ampicillin (anhydrous) 250 mg. A semi-synthetic penicillin effective against a wide range of both Gram-positive and Gram-negative organisms.

Indications: Treatment of infections due to Shigella, Salmonella, E. coli; H. influenzae, and P. mirabilis. Also for certain Gram-positive bacteria and treatment of infections in the urinary tract, the respiratory, and the gastrointestinal tract.

Dosage: Adults: 500 mg. every 6 hours for infections in genitourinary or gastrointestinal tract; 250 mg. every 6 hours for respiratory tract infections.

Children: Based on weight and severity of infections (100 mg. to 200 mg. in divided doses every 6 to 8 hours).

Supplied as: Capsules. Bottles of 24.

NEW COMBINATION PRODUCTS

POLY-VI-SOL with Iron

(Chewable Tablets) Vitamins Multiple with Minerals ℞

Manufacturer: Mead Johnson Laboratories

Composition: Vitamin A 4000 u.
Vitamin D 400 u.
Ascorbic Acid (C) 75.0 mg.
Thiamine (B-1) 1.2 mg.
Riboflavin (B-2) 1.5 mg.
Niacinamide 15.0 mg.
Ferrous Fumarate 40.0 mg.
(elemental iron 12 mg.)
Combines 6 vitamins with iron.

Indications: Prophylaxis of vitamin and iron deficiencies.

Dosage: One chewable tablet daily or as prescribed. May be chewed or dissolved in the mouth.

Supplied as: Chewable tablets. Bottles of 50.

POLY-VI-FLOR with Iron:

(Chewable Tablets) Vitamins Multiple with Minerals

Manufacturer: Mead Johnson Laboratories

Composition: Vitamin A 4000 u.
Vitamin D 400 u.
Ascorbic Acid (Vitamin C) 75.0 mg.
Thiamine (B-1) 1.2 mg.
Riboflavin (B-2) 1.5 mg.
Niacinamide 15.0 mg.
Fluoride (from sodium fluoride) 1 mg.
Ferrous Fumarate 40 mg.
(elemental iron 12 mg.)
Combines 6 vitamins with fluoride and iron.

Indications: Prophylaxis of vitamin and iron deficiencies and for reduction of dental caries.

Dosage: One chewable tablet daily for children 3 years and older—where drinking water content does not exceed 0.7 p.p.m. of fluoride.

Supplied as: Chewable tablets. Bottles of 50 and 1000.

TRI-VI-FLOR

(Chewable Tablets) Vitamins Multiple with Minerals ℞

Manufacturer: Mead Johnson Laboratories

Composition:
Fluoride (from sodium fluoride) 0.5 mg.
Vitamin A 4000 u.
Vitamin D 400 u.
Ascorbic Acid (Vitamin C) 75 mg.
Combines 3 vitamins with fluoride.

Indications: Prophylaxis of vitamin deficiencies and reduction of dental caries.

Dosage: One chewable tablet daily for children 3 years and older—where drinking water content does not exceed 0.7 p.p.m. of fluoride.

Supplied as: Chewable tablets. Bottles of 100 and 1000.

NEW DOSAGE FORM

NIFEREX TABLETS: Hematinics o-t-c

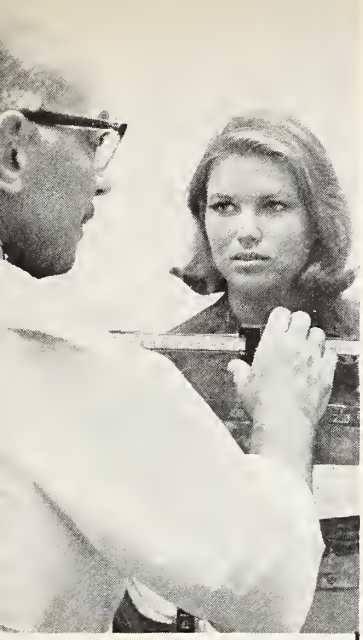
Manufacturer: The Central Pharmacal Co.

Composition: Elemental Iron 50 mg.
(as a polysaccharide, iron complex)
Iron complexed to a low molecular weight polysaccharide. The iron released is principally divalent (ferrous).

Indications: Iron deficiency anemias or as a supplement to the dietary intake of iron.

Dosage: Adults: 1 or 2 tablets daily.
Children: 6-12 years of age—1 tablet twice daily. 2-6 years of age—1 tablet daily.

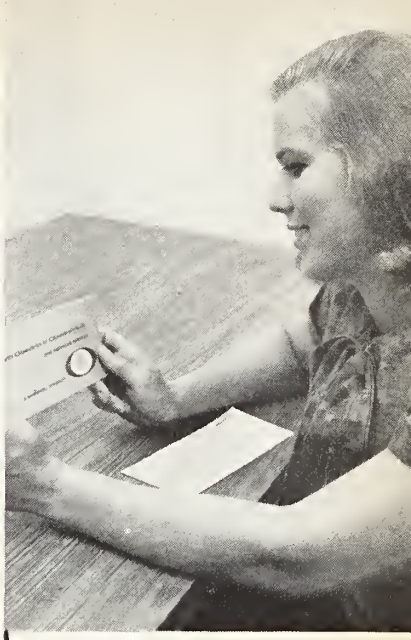
Supplied as: Brown sugar-coated tablets. Bottles of 100 and 1000.



1. YOUR SUPERVISION



2. "TRICKLE RELEASE" OBEDRIN-LA



3. OBEDRIN MENU PLAN

A WEIGHT CONTROL PROGRAM YOUR PATIENTS WILL STAY WITH . . . AND FEEL BETTER

1. YOUR SUPERVISION orients the patient to the need, goals and course of weight reduction . . . regular checkups confirm progress and support patient's morale.

2. OBEDRIN-LA: 1 tablet daily "trickle releases" medication for all-day appetite suppression.

3. OBEDRIN MENU PLAN: . . . aids weight reduction . . . provides a plan for necessary nutritional support and helps patients establish better eating habits.

Write today for free starter doses and Menu Plans, or contact your Massengill Representative.

DOSAGE is 1 tablet daily, usually at 10 a.m.

SUPPLIED in bottles of 50 and 250 tablets, on prescription only.

CAUTION: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage. Use with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution during pregnancy, especially in the first trimester.

LONG ACTING

Obedrin®-LA*

"TRICKLE RELEASE" TABLETS

Each tablet contains Methamphetamine HCl*, 12.5 mg.; Pentobarbital*, 50 mg. (Barbituric Acid derivative; Warning: May be habit forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Niacin, 10 mg. *U. S. Pat. Nos. 2,736,682; 2,809,916; 2,809,917; 2,809,918 and pat. pending.

MASSENGILL The S. E. Massengill Company, Bristol, Tennessee

New York • Chicago • Dallas • Kansas City • San Francisco

Rx Reviews

and New Products

Surgical Lubricant in Waste-Free Poly Dispenser



The Ulmer Pharmacal Company, Minneapolis, Minn., is now producing a water-soluble lubricant called Surgel in a polyethylene bottle which dispenses the greaseless, bacteriostatic lubricant for endoscopic procedures.

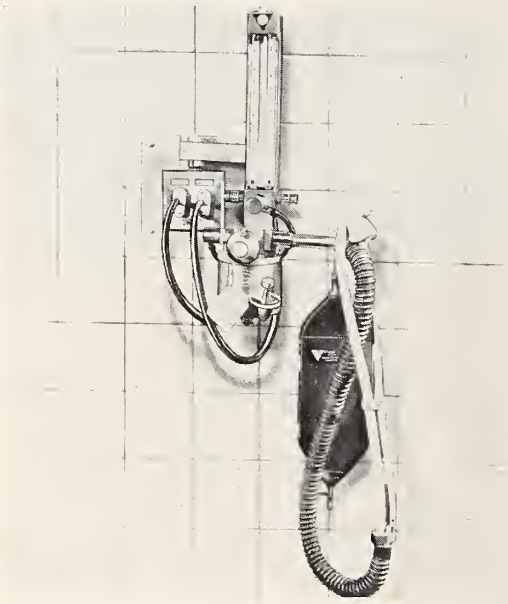
Surgel adheres to metal, glass, rubber or synthetic surfaces—wet or dry—with equal ease. Colorless and odorless, it is safe to use because it is nonirritating to mucous membranes and delicate tissues.

Because the compressible, new 8-ounce bottle dispenses Surgel on probes, catheters, thermometers and other instruments with "pinpoint" accuracy, there's no waste and it costs less to use.

Wall-Mounted Anesthesia Unit for Clinics

A wall-mounted anesthesia machine for dental clinics and hospitals is announced by the National Cylinder Gas division of Chemetron Corporation, 840 N. Michigan Ave., Chicago 60611.

The machine is said to provide quantitative anesthesia in clinics where floor space and working areas are at a premium.



The Quantiflex Wall-Mounted Anesthesia Machine can be used to administer oxygen, nitrous oxide or Fluothane. Its double swivel wall mount gives convenient access to the equipment and eliminates bulky apparatus occupying valuable floor space. The unit utilizes pipeline oxygen and nitrous oxide systems.

If mobility is desired, the unit can be mounted on a stand and moved from room to room for portable clinical application.

Each machine is equipped with flowmeters, Fluotec mount, double swivel arm, wall plate and bag adapter.

Continental Telephone Introduces Electronic Stethoscope

A new electronic stethoscope just introduced on the market makes it possible for doctors to clearly hear heart and breath sounds through clothing. This, however, is far from the major feature of this piece of medical equipment, which may someday permit obstetricians to accurately predict the sex of unborn children.

Developed by Continental Telephone

(continued on page 504)



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its antianxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
Cranbury, N.J.

CM-5761

. . . *Continued*

Supply Co., Inc., New York City, the medical listening instrument has been tested extensively at New York's Mount Sinai Hospital, where it was found that the stethoscope could pick up the heart beat of a month-old fetus. Completely transistorized, this stethoscope amplifies sounds several hundred times that of any conventional medical listening device.

The new Continental electronic stethoscope should also prove a boon to researchers. The controls on the stethoscope permit tuning for low heart tones or pulmonary tones and makes it possible to hear clearly faint murmurs, fetal heart sounds, sibilant rales and other phenomena of the human body that could not be distinguished previously. This should enable those in cardiovascular research to make significant forward strides in the coming years.

The electronic stethoscope also should have wide application insofar as teaching is concerned. It is designed so that it can be hooked up to a portable speaker. With the speaker attachment it can transmit heart sounds with extreme fidelity. It can therefore be used for continuous monitoring of a patient's heart beat in the operating room, in a class room, in consultation room or in other situations where amplification for a small or large group is required.

It will also be possible to tape record heart sounds with complete fidelity through a special recording attachment available with the stethoscope.

Hormonal Relief For Hay Fever

Sneezing and wheezing stopped or was greatly reduced in about 80% of 100 or more hay fever sufferers treated by a British physician over a 4-year period with a single injection of a well-known steroid.

A remarkable number of patients, who had tried everything else, now come back each year for repeat injections, according to the practitioner, Dr. B. Y. Marshall of Bletchingley, Surrey.

In comment published by the *British Medical Journal* (Oct. 9, 1965), Dr. Marshall said his experience has been that methylprednisolone (Depo - Medrone in Great Britain; Depo-Medrol in the U.S.—Upjohn Company) is the best treatment currently available for hay fever.

His statement was prompted by an earlier question-and-answer exchange in the magazine to the effect that use of steroids in hay fever was unjustified and might carry the risk of suppressing activity of the adrenal glands.

In his rebuttal, Dr. Marshall noted that one London teaching-hospital alone has given injections similar to those he has used in more than 30,000 out-patients during the past 6 years with no serious side-effects reported. He asked what new research had brought about the change in opinion from those expressed in the Medical Journal's columns in 1961 and 1963.

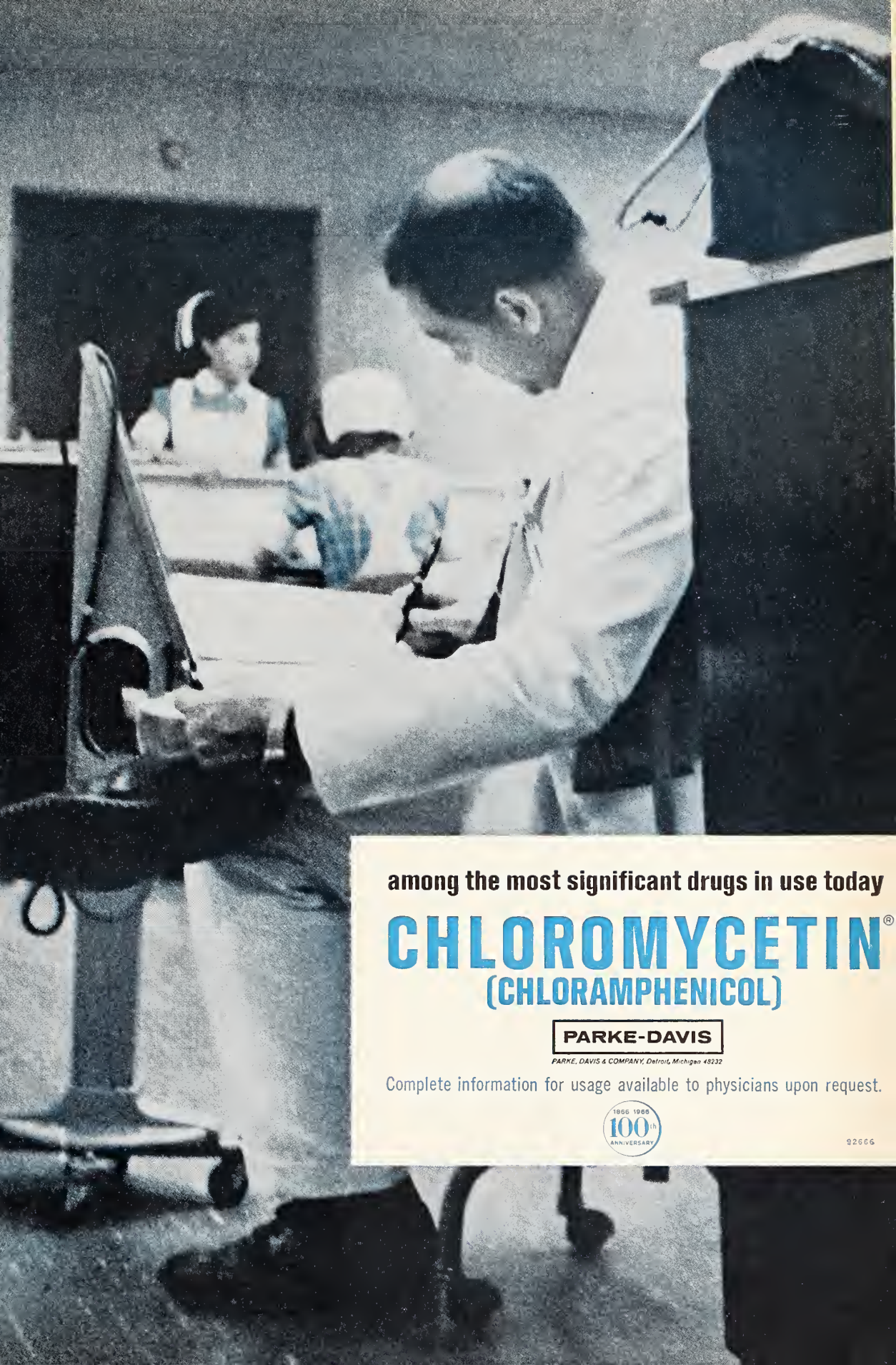
In reply, the magazine published another expert's opinion that a short course of steroids is certainly justified when the hay fever season is at its height or for social reasons. This was accompanied by a statement that steroid treatment throughout the several weeks the season lasts, is unjustified unless severe asthma accompanies the hay fever.

If Dr. Marshall's results are confirmed, his suggested method of treatment seems to be reasonable since any suppression of the adrenals that followed a single steroid injection would be very temporary, the expert commented.

In another report published in *Practitioner* (May 1965), Dr. Marshall stated that a single intramuscular injection of methylprednisolone gave nearly complete relief of symptoms for the whole season to 18 of 20 patients with hay fever or allergic rhinitis.

Except for two 14-year-olds who were given doses of 40 milligrams of the drug, these patients received injections of 80 milligrams. Shots were administered from March to October, 1963, and several follow-up observations were made, including one in January, 1964.

Eighteen patients were still free of symptoms at the time of the final observation and nearly all thought the results were better than their previous experience with antihistamines, Dr. Marshall said. The two patients who got no relief with methylprednisolone had fared no better on antihistamines, he added.



among the most significant drugs in use today

CHLOROMYCETIN®
(CHLORAMPHENICOL)

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

Complete information for usage available to physicians upon request.

1866 1966 100th ANNIVERSARY

92666

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

BEST FOR THE PATIENT IS BEST FOR YOU

"A doctor's office is one of the most difficult places in which to work," said Mr. Elbert Cooper from Professional Management of Bloomington, speaking to the Central Branch of the Cook County Medical Assistants Association on "Office Management or Mis-Management." There are many reasons for this: the terminology, the nature of the work, the hours required. Also the medical assistant must often be secretary, receptionist, bookkeeper, laboratory assistant, nurse, etc. No other profession requires competence in so many areas.

The gross income from a doctor's practice will generally be proportional to the time spent by the doctor seeing patients. On the other hand, the net profit of the practice depends on several factors—efficient office management, costs, appointment scheduling, collections and fees. In a personal service type of endeavor, such as the practice of medicine, there is a limit to the amount of time that can be devoted to producing income. In a solo practice, a doctor cannot work "around the clock." Therefore, rising costs can only be offset by finding ways to reduce them, such as increasing fees or working longer hours. The medical assistant has some control of these factors. It is important to utilize time so that it becomes the doctor's ally. Whenever the medical assistant can do something as well or better than the doctor, she should make every effort to do so. This frees his time to do those things which only he can do, that is, see patients, diagnose, treat and cure.

Public relations are very important to the successful practice of medicine. Nowhere else in business is attention to the smallest detail so important as in patient relations. In the doctor's business the patient is the most important element. He may be considered a cold statistic at times, but is also flesh and blood with deep-rooted human interests, motivations, wants and desires, as well as biases and prejudices —all of which must be recognized. He requires constant cultivation and observation. It is impossible to know too much about him. His habits, income, interests, motivations, wants and desires change. It is important to study these changes and make timely adjustments to conform.

Mr. Cooper said, "We use the expression 'What's best for the patient is best for the doctor is best for professional management.' This can be paraphrased to become 'What's best for the patient is best for the doctor is best for you, his office assistant'."

Mark the calendar to allow your assistant time off to attend the I.M.A.A. convention in Bloomington, Illinois on April 22, 23, and 24. The speakers and their topics are as follows:

"The Tension State"—A. Edward Livingston, M.D., current president of the Illinois Society of Internal Medicine. Illustrated lecture.

"Explanation of Medicare Procedures" —Mr. Lee Forrest, from the Bureau of Health Insurance

"The Hidden Sickness"—Mr. Robert Marr, Jr.—Smith Kline, & French Laboratories on barbiturates and amphetamines.

"Foods Out of this World"—Mr. Justin Alikonis—chemist who has worked on foods for the Space Program. He will furnish "survival kits."

LOOKING FOR A PLACE TO PRACTICE?

PLACEMENT SERVICE LISTS OPENINGS

Following is a sample of the more than 150 openings for general practitioners listed with the Illinois State Medical Society's Physicians' Placement Service. Interested physicians who register with the service will be provided with a complete list of openings. Inquiries and comments should be directed to: Mrs. Robert Swanson, Secretary, Physicians' Placement Service, Illinois State Medical Society, 360 North Michigan Avenue, Chicago 60601, STate 2-1654.

Vermilion County: Rossville: population 1500. Estimated population of trade area, 3200. One physician, age 65, trying to retire. Second physician retired recently after practicing here for 30 years. Nearest hospital, 7 miles. Nearest large city, Danville, 20 miles; population 41,200. Attractive office and home of retired physician available if desired. 6 room office with basement and 2 car garage attached. 8 room home with full basement. Office equipment of retired physician for sale or rent if desired. Agricultural area. Many residents employed in nearby factories. Churches: Presbyterian, Methodist, Church of Christ, Baptist and Nazarene. Local grade and high schools. Organizations include Womans Club, Jr. Womans Club, PTA, American Legion and Auxiliary, Masonic Lodge, Eastern Star, Commercial club. Excellent country club with golf course and swimming pool. Rossville is located 115 miles south of Chicago and 20 miles north of Danville. Served by Central and Eastern Illinois Railroad and is located on Illinois route 1. Rossville Packing Company employs 200 people at canning time.

Fulton County: Lewistown; population 2700. Estimated population of trade area, 7500. Urgent need for a physician. Town has always supported two or three physicians. Only physician at present time is 87 years of age. Nearest physicians, 9 and 13 miles. Second physician moved in October 1965 to take a surgical residency. 40 miles from Peoria—population 130,000. 2 prescription drug stores. Excellent office facilities available. Pictures upon request from Illinois State Medical Society. Financial assistance could be arranged. Principal sources of income: strip mining, agriculture and factories. Lewistown is county seat. Protestant and Catholic churches. Grade and high schools. Active organizations include Chamber of Commerce, Kiwanis, Optimists, IOOF and masonic Lodge. Nearby country club. Construction of a large nursing home underway; medical advisor needed.

Lake County: Mundelein. Population 14,400. Opening for an associate, full or part time, with opportunity for a partnership. Financial arrangements are open for discussion, either a straight salary or gradually increasing percentage, depending on qualifications and experience. Internist or pediatrician, board eligible or qualified, preferably with some subspecialty training. Also, Ob-Gyn, ENT, surgeon, dematologist, or a qualified GP with some specialty training. Rapidly growing community of 15,000 and a drawing area of about 12,000, 40 miles from Chicago Loop. Modern new office building with 12 examining rooms, approved clinical laboratory, EKG, physical therapy and other clinical facilities. Office space is also available for rent in the case of desire to start independent, solo practice.

McLean County: Bloomington: Population: 38,000. Population of nearby Normal, 20,000. County population: 100,000. 96 physicians in county, including 3 in this specialty. Hospitals: St. Joseph's, Brokaw, and Mennonite—all enlarging at this time. Over 700 beds. Open staffs. Primary sources of income in community: agriculture, industry and State Farm Insurance Company. Excellent schools. Colleges: Illinois State Normal and Illinois Wesleyan. Excellent recreational facilities. Community and county medical society would welcome two more physicians in this specialty. Hospitals fully accredited. Many fine highways and the hub of state four lane roads, 66, 74, 55, etc. Gross collections last year over $52,000 without surgery, face fractures and nosebleed fees.

Douglas-Piatt County: Atwood: population 1500. Estimated population of trade area: 4,000. Only physician died July 1965. Nearest physicians, 6 miles. Nearest hospital at Tuscola, 10 miles. Nearest large city, Decatur, 30 miles; population—80,000. No local prescription drug store. Office space available. Financial assistance could be provided if desired. Sources of income: agriculture and industry (U. S. I. Chemical Plant). Churches: United Church of Christ, Methodist, Baptist and Christian. Grade and high schools. Nearest college, Millikin at Decature. Organizations include Lions, American Legion and Auxiliary, Womens Club, etc. Adequate recreational facilities within 8 miles.

NEWS and ANNOUNCEMENTS

Illinois Doctor Reports Project Vietnam Service

Sitting in a bare hospital clinic that he painted himself, Dr. Martin Funk of 1241 Tyrell Avenue, Park Ridge, Illinois, counted the patients he had just treated. "Eighty seven," he noted. "A slow morning."

The fact that there were any patients at all that morning represented a modest triumph for Dr. Funk. He recently served with Project Vietnam, an Agency for International Development-sponsored program through which American volunteer physicians served 60 day tours in Vietnam, usually in provincial hospitals. He had arrived in Vietnam's remote highland province of Kontum two months earlier.

When he came to the 66-bed hospital, which handles all the civilian medical needs for the more than 74,000 inhabitants of Kontum, he found one Vietnamese doctor, Dr. Thach, and a six man Filipino surgical team with their hands full caring for the patients in the hospital. There was no clinic available for those who needed care but did not require hospitalization.



In the outpatient clinic at the Kontum province hospital, Project Vietnam Doctor Martin Funk examines a young boy. His interpreter is on the right. In the rear, U.S. Army Dr. Marsh, who assists Dr. Funk in the clinic, also checks a patient.

"My primary concern in medicine is to keep people well," said Dr. Funk who normally practices medicine at the Fahey Medical Center in Des Plaines, Ill. "I am interested in controlling ailments in their early stages so people don't have to go to the hospital." Hence he decided to begin an outpatient clinic.

"I started with nothing," he said. "No interpreter, technicians, nurses, or medications." He secured an extra room in the hospital for his clinic, painted it, and put in fluoreseent lights and running water. A United States Army medical personnel doctor stationed in Kontum, volunteered to assist with the clinic. "We started with a couple of bottles of pills," said Dr. Funk.

"The first day I walked into the room and began to collect patients," he said. Since he had no interpreter, he asked among the patients for someone who spoke English. Later one of the patients, a police officer, promised to find him one. Eventually the doctors developed a staff of unpaid, volunteer workers many of whom were local students who wanted to improve their English.

They began with fewer than 20 patients. "Then," said Dr. Funk, "news about the clinic began to snowball. In less than two months we were handling as many as 121 patients in a single morning."

Weekends, Dr. Funk went out to villages in the province with American soldiers to hold sick call. Some of the villagers had never seen an American.

Dr. Funk worked at establishing rapport with these people, many of whom were primitive mountain tribesmen or montagnards. "Usually when we went into a village, they would seem apprehensive," he

said. "But after five or ten minutes, they would start to relax and by the time I left, they would be very amiable.

"We would always try to leave the message with the people that if they were ill, they should come to the clinic for care."

Many of them did come, including Viet Cong prisoners brought in by the police. Their diseases included pneumonia, arthritis, tapeworm, diarrhea, and tuberculosis.

"I think I have seen more TB here than in my entire practice at home," said the doctor. Pneumonia, dysentery, malaria and cataracts are also very widespread, he noted. "We could keep three ophthalmologists busy full time here," he said. There is, however, only one in Vietnam at the US Navy Hospital in Saigon.

"I went to Vietnam," he said, "because I felt there was something to be done and I was available to help. My work was satisfying. I liked the people and enjoyed the work."

Dr. Funk, who is now back in Illinois, is the son of Mr. and Mrs. Martin J. Funk of Prospect Heights. He received his BS degree from Loyola University in Chicago and his MD from Stritch School of Medicine at Loyola. He is a member of The Chicago Medical Society, the Illinois State Medical Society, the American Medical Association, and a fellow of the Academy of Psychosomatic Medicine.

Illinois Physicians Begin Accident Victims Blood Studies

In accordance with a new state law, Illinois physicians began January 1 to draw blood specimens from each driver, suspected driver, occupant of a motor vehicle, or pedestrian killed in an accident involving a motor vehicle. Blood specimens are to be taken upon request of the local county coronor within 24 hours of death and prior to embalming. Analysis of these specimens will be made by the Illinois Department of Public Health laboratory (except in Cook County where the laboratories of the Cook County morgue will be utilized) to determine the amount of alcohol or carbon monoxide present.

Purpose of this amendment to the Coronor's Act passed by the 74th General Assembly is to determine the relationship between alcohol and/or carbon monoxide to deaths when a motor vehicle is involved. It is estimated that there will be approximately 2,400 deaths among individuals falling within the purview of this study in Illinois in 1966 and the statistics will be used to provide factual data for traffic safety programs.

There is no provision in the legislation for paying physicians or hospitals for drawing the blood specimen, but immunity from all liability, civil or criminal, is provided for any person drawing blood at the request of the local coronor.

Hektoen Establishes New Lecture Program

An annual lecture program in memory of one of the nation's most eminent scientists in the study of children's heart disease, Dr. Benjamin M. Gasul, has been established at Hektoen Institute for Medical Research of the Cook County Hospital, according to an announcement by Dr. Robert A. Miller, director of the pediatric cardiology departments of Hektoen and Cook County Hospital, and chairman of the program.

The first lecture was given by Dr. Robert L. DeHaan, a nationally known research embryologist of the Carnegie Institute of Washington (D.C.), on March 9, in the Hektoen auditorium.

Dr. Gasul, one of the first pediatricians to devote himself to the study of heart disease in infants and children, founded the pediatric cardiology departments of Hektoen and the hospital in 1946. He served as director of the departments until his death in 1962.

Dr. DeHaan, who discussed his extensive studies into the development of the embryonic heart, is especially noted for adapting modern research techniques to the study of the growing embryo. One of his major interests has been the development of time-lapse motion picture photography to record the development of the living chicken embryo.

Since Dr. Gasul's establishment of the pediatric cardiology facility at Hektoen, numerous new conditions have been described and many special techniques in diagnosis of infants' and children's heart disease have been developed, according to Dr. Miller.

Hektoen Develops Simplified Surgery for Hydrocephalus

Simplified surgery for treating hydrocephalus, a disorder causing mental retardation that afflicts about one newborn in every 850, has been developed at Hektoen Institute for Medical Research of the Cook County Hospital.

"With the new procedure, the operation is accomplished in 20 minutes under a local anesthetic as compared to two hours under general anesthetic using previous methods. The development is particularly significant, since hydrocephalic babies are usually premature and any surgery performed on them should be as brief as possible," said Dr. Samuel J. Hoffman, Institute director.

More than 40 infants have undergone successful surgery with the new procedure since its introduction last year by Dr. Anthony J. Raimondi.

The advanced method of surgery came about through Dr. Raimondi's design of special instruments for the operation together with the revival of an older means of draining the fluid which accumulates in the head of a hydrocephalic.

Dr. Raimondi gave a brief outline of the operation: 1. Sedatives and local anesthetic are administered; 2. Half-inch incision is made on rear quarter of head and a small (3/16-inch) opening is made in the skull; 3. An instrument designed at Hektoen that functions much like a large, hollow needle is inserted into a ventricle of the brain. Tubing is put into place via the bore of the instrument; 4. Instrument is removed, sliding along the tubing and leaving it in; 5. Similar procedure with similarly developed instrument is performed at the child's abdomen; 6. A special guide developed at the Institute is passed under the skin to connect the two terminals with tubing; 7. The tubing is anchored and the incisions are closed.

TWO MAGIC WORDS

"OPEN ENROLLMENT"

ILLINOIS STATE MEDICAL SOCIETY GROUP DISABILITY PLAN

Look for the Certificate of Extra Membership Privilege Mailed to You

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance
Administrators

9933 LAWLER AVENUE SKOKIE, ILLINOIS PHONES 679-1000

skin

The cancer with the highest incidence: skin. The cancer with the highest mortality rate: lung. Both, ironically, the most preventable of all cancers.

Lung cancer kills some 47,000 Americans every year. Estimates are that more than 75% of lung cancers are caused by cigarette smoking...a preventable habit.

About 80,000 Americans develop skin cancer each year. Since its principal cause is excessive exposure to the sun, preventive measures are clear.

Basal cell and squamous cell carcinoma, commonest forms of skin cancer, are easily cured in their early stages. The high incidence of skin cancer, the suffering, disability and disfigurement which too often accompany it, make it a challenging problem.

In its program of bringing vital facts about cancer to the public, the Society has two new films, both available for showing through any ACS Unit. WHO, ME? dramatizes the hazards of cigarette smoking. SENSE IN THE SUN urges both sun workers and sun worshippers to exercise caution. Like all Society films, their object is to save lives and diminish suffering from cancer by giving forceful expression to many of the facts about cancer with which you, doctor, guide your patients.

american cancer society ®

lung

Illinois Division, 37 S. Wabash Avenue
Chicago, Illinois 60603
FRanklin 2-0471

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
Starting Dates — 1966

SPECIALTY REVIEW COURSE IN MEDICINE, Part II, June 6
SPECIALTY REVIEW COURSE IN ORTHOPEDICS, April 18
SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 16
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
GENERAL SURGERY, Two Weeks, April 18
BLOOD VESSEL SURGERY, One Week, May 9
SURGERY OF THE HAND, One Week, May 9
ADVANCES IN SURGERY, One Week, May 16
PROCTOSCOPY & SIGMOIDOSCOPY, One Week, May 9
TREATMENT OF VARICOSE VEINS, One Week, May 9
VAGINAL SURGERY, One Week, May 9
GYNECOLOGY, Two Weeks, June 6
BASIC INTERNAL MEDICINE, One Week, April 25
ADVANCES IN MEDICINE, One Week, May 9
GENERAL PRACTICE REVIEW, One Week, May 23
CLINICAL USES OF RADIOISOTOPES, Two Weeks, April 25
DERMATOLOGY, One Week, April 25
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

TEACHING FACULTY
Attending Staff of
Cook County Hospital
Address: REGISTRAR, 707 South Wood Street
Chicago, Illinois 60612

underachievers

A residential facility for Junior and Senior High School males who need psychiatric help with: ■ Problems of academic underachievement and attendance . . . ■ Difficulties in family-school-social adjustments.
Complete academic and therapy program for grades 7 through 12.

For information contact: Rita Burgett, Secretary
The Readjustment Center
Box 373, Ann Arbor, Mich.
Phone: (AC 313) 663-5522



Physicians' Role To Be Discussed At Medical Student Conference

"The Physicians' Role in the Community" is the theme for the second annual Student American Medical Association Conference scheduled for April 23 at the Sheraton-Chicago.

More than 7,000 students, interns, residents and their wives from Cook, Will, DuPage and Lake Counties, Illinois and Lake County, Indiana, have been invited to the event, co-sponsored by the Illinois State Medical Society and the Chicago Medical Society through a grant by Lederle Laboratories.

The program, announced by Dr. Maurice M. Hoeltgen, Chicago, chairman of the ISMS Advisory Committee to the Student AMA, begins with a discussion on "Sex Education in the Community," by Dr. Frank Loeke, chief of the department of obstetrics at Emma L. Bixby Hospital, Adrian, Michigan.

Dr. Tennyson Guyer, public relations director of the Cooper Tire and Rubber Co., Findlay, Ohio will give a luncheon address on "People Who Live in Glass Houses Shouldn't."

The program also includes a discussion of "Alcoholism in the Community" by Dr. Beverley T. Mead, chairman of the departments of psychiatry and neurology, Creighton School of Medicine, Omaha, Nebr.; "How to Stay Out of Legal Difficulty," Richard P. Bergen, Law Department, American Medical Association; "The Physician and His Civic Responsibility," Dr. James B. Donaldson, professor of clinical medicine, Temple University School of Medicine, Philadelphia; and a panel discussion led by Arthur Snider, science writer, The Chicago Daily News.

A special afternoon program for wives will include a demonstration-lecture on Flower Arranging and another on Practical Charm.

WATCH FOR SPECIAL MAILINGS GIVING DETAILS OF THE ANNUAL CONVENTION PROGRAM AND SOCIAL EVENTS.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO OFFICE: Tom J. Hoehn and E. M. Breier, Representatives
55 East Washington Street, Room 1334, Chicago 60602 Telephone: 312-782-0990
MOUNT PROSPECT OFFICE: Theodore J. Pandak, Representative
709 Hackberry Lane (P. O. Box 105) Mount Prospect 60056 Telephone: 312-259-2774
ST. CHARLES OFFICE: Joseph C. Kunches, Representative
1220 Wing Avenue, St. Charles 60174 Telephone: 312-584-0920
SPRINGFIELD OFFICE: William J. Nattermann, Representative
1124 South Fifth Street, Springfield 62703 Telephone: 217-544-2251

Fully *Accredited*

NSH

North Shore Hospital

225 Sheridan Rd. **WINNETKA, ILLINOIS**

Care and treatment of emotional disorders

◆

for information contact:
Milton A. Dushkin, M.D.
MEDICAL DIRECTOR
Hillcrest 6-0211

Dermatological Society Elects New Officers

At the annual meeting of the Chicago Dermatological Society, held recently, the following officers were elected: President: Samuel W. Becker, Jr., M.D.; Vice-president: David W. Kersting, M.D.; Secretary: John B. Haeberlin, Jr., M.D.; and Treasurer: Milton Robin, M.D.

Michael Reese Hospital and Medical Center Affiliate with Chicago Medical School

Complete academic affiliation between the Chicago Medical School and Michael Reese Hospital and Medical Center has been announced by the two institutions.

Thus, Michael Reese Hospital and Medical Center joins the ranks of Mount Sinai Hospital Medical Center in becoming a major total academic affiliate of the Chicago Medical School.

The announcement was made jointly by Dr. John J. Sheinin, president of the Chicago Medical School; Harold H. Hines, Jr., president of Michael Reese Hospital and Medical Center and Solomon Katz, president of Mount Sinai Medical Center.

Dr. Sheinin said the new affiliation now makes it possible for joint use of faculty, staff members and teaching at all levels—undergraduate, graduate and postgraduate—from three major Chicago medical institutions, the Chicago Medical School, Michael Reese and Mount Sinai.

"The agreement represents a united effort by three major institutions to further enhance medical education, medical research and patient care," Dr. Sheinin pointed out.

"This combination of scientific talent and superior medical resources will be of substantial benefit to the Chicago community and the nation," he added.

The educational program in each hospital is administered by an assistant dean who is also director of medical education in each respective hospital and who is appointed jointly by the School and the hospital.

CANDIDATES FOR
"THE MOST EFFECTIVE SUNSCREEN"[1] OR WINDSCREEN

RVP®-ELDER
RED PETROLATUM



RVP-Elder, called "the most effective sunscreen," is also an ideal windscreen.

Constant occupational exposure to sun and wind often causes major discomfort in producing irritating sunburned and windburned skin . . . commonly found in street workers, construction workers, and telephone linemen, to mention a few.

There's reassuring protection and skin comfort for those outdoor workers who use RVP-Elder. Swimmers, golfers and others engaged in outdoor activities can have the same skin protection.

A razor-thin layer of only 10 microns adheres tenaciously to the skin for hours, yet washes off easily with soap and water. Virtually invisible, RVP-Elder is odorless, non-staining, and perspiration and water resistant, even while swimming. No sensitivity has been encountered.

Supplied in 2 oz. and 16 oz.
Write for clinical trial package and absorption spectrum

References: (1) Schoch, A. G.: Current News in Dermatology, August, 1963; (2) Jillson, O. F., and Baughman, R. D.: Arch. Dermat. 88:409, 1963; (3) Cole, H. N., et al.: J.A.M.A. 130: 1, 1946; (4) MacEachern, W. N., and Jillson, O. F.: Arch. Dermat. 89: 147, 1964.

ALSO AVAILABLE: NEW RVP Aerosol, RVP-2, RVPaque, RVPellent

PAUL B. ELDER COMPANY • Bryan, Ohio

Twenty-five Clinics for Crippled Children Listed for May

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will count eighteen general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and three for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May 3 Fairfield—Fairfield Memorial Hospital

May 3 Pittsfield—Illini Community Hospital

May 4 Hinsdale—Hinsdale Sanitarium

May 5 Litchfield—Madison Park School

May 5 Sterling—Community General Hospital

May 5 Peoria Cerebral Palsy (half-day)—Roosevelt School

May 10 Peoria General—Children's Hospital

May 10 East St. Louis—Christian Welfare Hospital

May 11 Champaign-Urbana—McKinley Hospital

May 11 Joliet—Silver Cross Hospital

May 12 DuQuoin—Marshall-Browning Hospital

May 12 Springfield General—St. John's Hospital

May 13 Chicago Heights Cardiac—St. James Hospital

May 17 Alton General—Alton Memorial Hospital

May 18 Rock Island Cerebral Palsy—Foss Home, 3808 Eighth Avenue

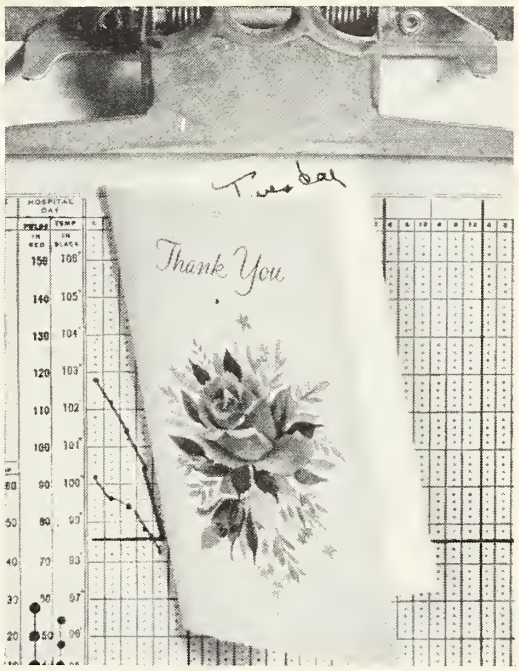
May 18 Evergreen Park—Little Co. of Mary Hospital

May 19 Rockford—Rockford Memorial Hospital

May 19 Decatur—Decatur & Macon Co. Hospital

May 19 Elmhurst Cardiac—Memorial

(continued on page 518)



DID YOU EVER GET A "THANK YOU" NOTE FROM A SPECIAL-DIET PATIENT?

It can happen. Get hold of our free booklet and see the remarkable things that can be done with a diet that is built on Cream of RICE.

It's called "How To Make A Special Diet Taste Extra Special!" You'll find delicious recipes for bland, wheat-free, milk-free, egg-free and low-salt diets.

A recent research study compared the breakdown of Cream of RICE with oat, wheat, corn and barley cereals and concluded that Cream of RICE was easiest to digest.

Cream of RICE is fortified with Vitamin B_1, Riboflavin, Niacin and Iron. And it's low in residue and fat. The patient gets dietary protection, flavor satisfaction and good nutrition. And you may actually get a "Thank you."



ADVERTISED IN Reader's Digest

15½ million families (26 million worldwide) buy each issue.

CREAM OF RICE, Box IL 46, West Chester, Pa. 19380

Please send_____(state number desired) free copies of "How To Make A Special Diet Taste Extra Special!" to

Name_____

Address_____

City_____

State_____ Zip Code_____

Hospital of DuPage County

May 24 Peoria General—Children's Hospital

May 25 Centralia—St. Mary's Hospital

May 25 Springfield Cerebral Palsy (P.M.)—Memorial Hospital

May 25 Elgin—Sherman Hospital

May 26 Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

May 27 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurses association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Dr. Effie Ellis Honored

Dr. Effie O. Ellis, Children's Bureau Regional Medical Director for Region V, in Chicago, was presented with a special award at the Second Annual Ohio Congress of the Ohio Division of the American Association for Maternal and Child Health, held in Columbus, March 1-3.

Dr. Ellis was cited by the officers and members of the group for "her tremendous efforts and her constant encouragement in the activities of the Ohio Division."

Before joining the Children's Bureau staff last year, Dr. Ellis was Chief of the Division of Maternal and Child Health in the Ohio State Department of Health. She is a graduate of the University of Illinois College of Medicine. She served her internship and residency in pediatrics at the Massachusetts General Hospital and later was a fellow in pediatric cardiology at Johns Hopkins Hospital.

Methodist Hospital Graduate Medical Center

Indianapolis, Indiana

Invites Practicing Physicians

To

Attend a Graduate Course on

ALLERGIC DISEASE AND IMMUNE MECHANISM

May 20, 21 and 22, 1966

This course will cover the field of allergy from a practical viewpoint. Demonstrations of proper skin testing techniques and methods of treatment will be included.

The registration fee ($35.00) will include a book which will cover the practical care of allergic disease. The entire course is geared to help the practicing physician better care for the allergic patient. The book will contain all the lectures in detail, as well as aspects which cannot be completely covered within a few days.

The lectures will be supplemented by Kodachrome studies and round table discussions with question and answer periods.

The program is approved for 15 hours credit in Category I by the American Academy of General Practice.

For further information write:

Department of Medical Education
Methodist Hospital Graduate Medical Center
Indianapolis, Indiana 46207

Hospitalization For Emotionally Disturbed Patients

- MERCY HOSPITAL, Urbana, Ill., a not-for-profit general hospital, offers a Completely Modern, 30-bed Psychiatric Unit.
- The Unit is an evaluation & intensive treatment center, not intended for the care of the incurably mentally ill.
- It is equipped to offer more Intensive Care at Less Expense, Quickly Available Care, a Consultative Staff in Many Specialties, and has three Board-Qualified Psychiatrists on the Staff.
- All Physicians, staff and non-staff are invited to make psychiatric referrals.

For information concerning admission:

PSYCHIATRIC UNIT—MERCY HOSPITAL
1412 West Park Street, Urbana, Illinois
Area Code 217—Ph. 367-6621 Ex. 513

2 Approved Group Insurance Plans

for members of

THE ILLINOIS STATE MEDICAL SOCIETY

GROUP DISABILITY PLAN

TOTAL DISABILITY CAN BE COSTLY
Review Your Needs Today
Amounts Available up to
$250.00 Weekly

SPECIAL FEATURES

- SICKNESS BENEFITS TO AGE 65 PLAN
- THREE EXCELLENT PLANS TO CHOOSE FROM
- CONVERSION PLAN AVAILABLE AT AGE 70
- LOW RATES UNDER A TRUE GROUP POLICY

GROUP MAJOR MEDICAL PLAN

$15,000 MAXIMUM BENEFIT

Choice of 2 Deductibles

Dependent Coverage Available

Both IN and OUT of Hospital Expenses Included

Truly Catastrophic Protection

GROUP POLICY RATES

CALL OR WRITE

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance
ADMINISTRATORS

9933 LAWLER AVENUE SKOKIE, ILLINOIS PHONES 679-1000

Nervous
Geriatrics

Long Term and Short Term Care



Est. 1909

Mental
Custodial

Day Care and Mental Health Clinic

RESTHAVEN

This modernly equipped institution located in the beautiful Fox River Valley 35 miles west of Chicago, cooperates with physicians to the fullest extent.

It provides accommodations for 100 patients in single and double rooms. Resthaven accepts patients by referral and direct admission.

RESTHAVEN HOSPITAL, 600 VILLA ST., ELGIN, ILL.
Phone: SH 2-0327

OBITUARIES



Harold A. Grimm, M.D., was born June 17, 1915 and died March 16, 1966.

Dr. Grimm received his B.S. degree from the University of Illinois College of Medicine and his M.D. degree in 1940, following completion of a one-year rotating internship at the Milwaukee County Hospital, Wauwatosa, Wisconsin. He served as a resident in Pathology at the University of Illinois' Research and Educational Hospitals from 1940 until 1942.

He was associated in the practice of pathology with Coye C. Mason, M.D. and S. Steven Barron, M.D. and was pathologist and director of laboratories for Geneva Community and Delnor Hospitals. He was professor of clinical pathology at the University of Illinois College of Medicine.

Dr. Grimm was a co-founder and director of the Chicago Blood Donor Service, a not-for-profit community blood bank, and a past president of the Illinois Society of Pathologists. He also served as a member of the Executive Committee of the Illinois Association of Blood Banks.

He is survived by his widow, Loretta; a son, Edward; two daughters, Marilyn and Patti; his mother, Mrs. Kathryn Grimm; and a brother and sister.

John D. Boggs*, Fairfield, died February 27, aged 90. A graduate of St. Louis University School of Medicine in 1905, he retired in 1954. He was a member of the Fifty Year Club of ISMS.

Dominic di Ciro*, Olney, died February 11, aged 72. In 1917 he graduated from St. Louis College of Physicians and Surgeons.

Theodore G. Giese*, Harvey, died February 25, aged 70. In 1922 he was a graduate of Loyola University School of Medicine. He had been a staff member of Ingalls Memorial hospital and was a partner of the Community Medical center.

Sol M. Goldberger*, Chicago, died March 16, aged 80. In 1908 he was a graduate of the University of Illinois College of Medicine. A staff member of the Norwegian-American hospital for 50 years, he retired in 1963. He was a member of the Fifty Year Club of ISMS.

Jack R. Lavieri*, Chicago, died March 10, aged 76. A graduate of the University of Illinois College of Medicine in 1912, he specialized in obstetrics and gynecology. He was former associate professor of gynecology and obstetrics at Loyola University School of Medicine, founding member of the American College of Gynecology and Obstetrics and a life member of the American College of Surgeons. Dr. Lavieri was a member of the Fifty Year Club of ISMS.

David I. Lewis*, Chicago, died March 3, aged 72. In 1921 he graduated from Loyola University School of Medicine. He was formerly supervisor for the Chicago board of health and was a staff member of Lutheran Deaconess and Weiss Memorial hospitals.

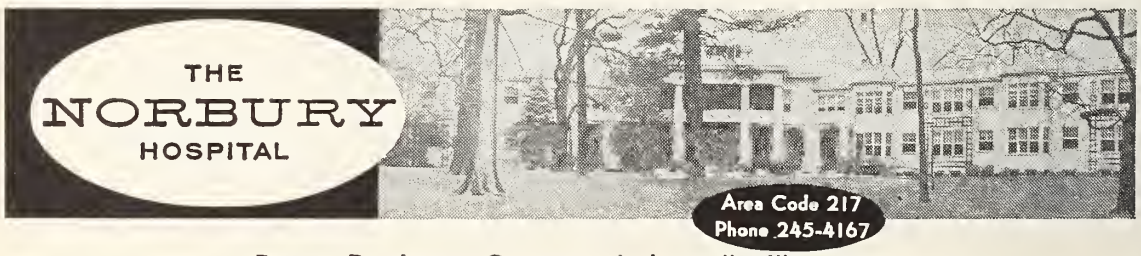
Lars E. Lundgoot*, Des Plaines, died February 16, aged 63. A graduate of Loyola University School of Medicine in 1930, he specialized in pediatrics.

Charles A. Potter*, St. Charles, died February 27, aged 87. In 1902 he graduated from the University of Illinois College of Medicine. First chief of staff of Delnor hospital, he became an honorary staff member upon retirement in 1964. He was past president of Kane County Medical Association and a member of the Fifty Year Club of ISMS.

Sophie Sloman*, Oak Park, died March 7, aged 61. A graduate of the University of Illinois College of Medicine in 1928, she specialized in child psychiatry. She was founder and medical director of the Southwest Suburban Mental Health Clinic.

Lester Wishingrad*, Chicago, died February 26, aged 52. A graduate of Chicago Medical School in 1952, he specialized in pediatrics.

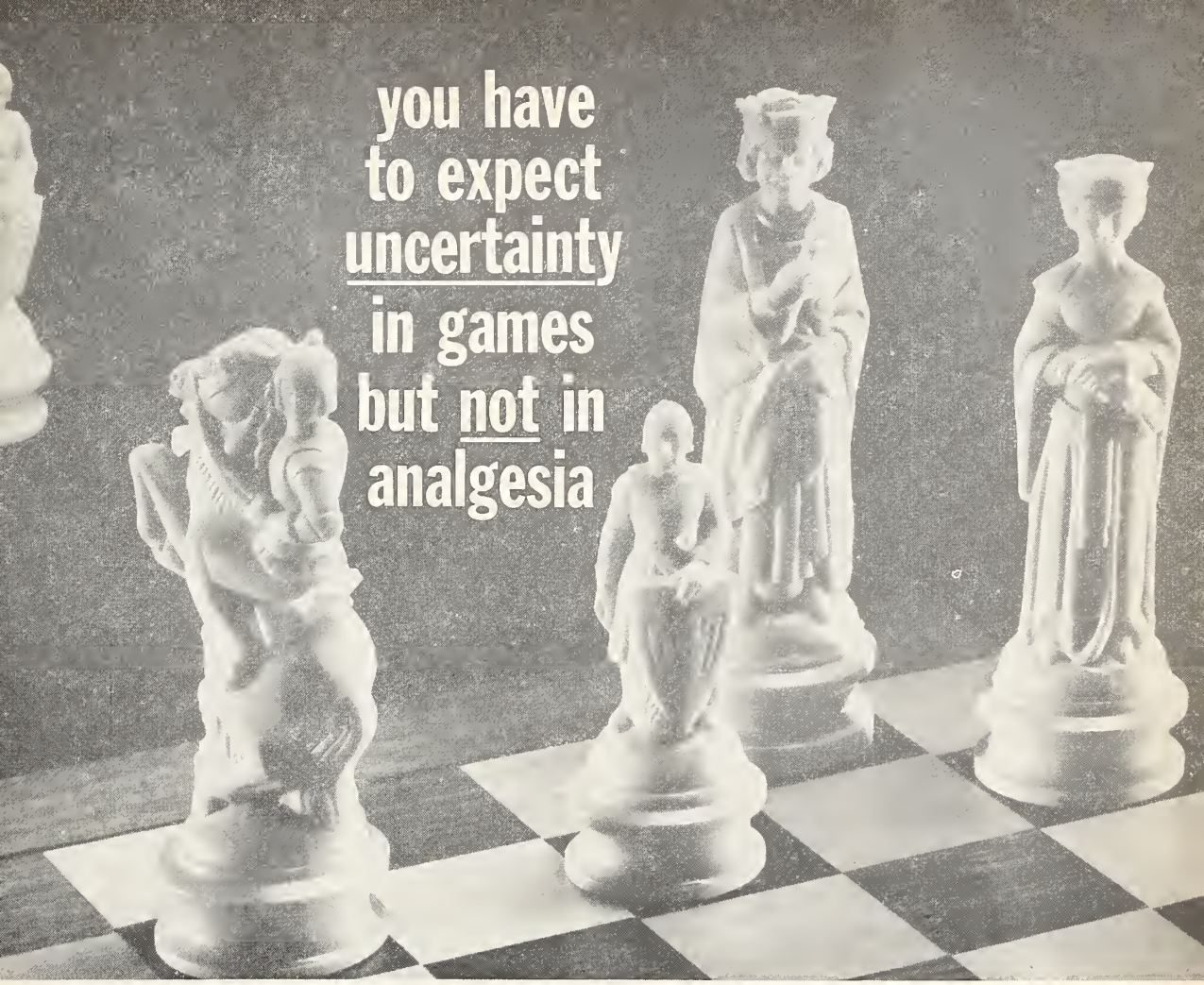
**Indicates member of Illinois State Medical Society.*



a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).



Time after time, in patient after patient, PERCODAN's pain-killing action is fast, potent and predictable. Enthusiasm for PERCODAN by physicians is almost directly proportional to their experience with this analgesic formula. Just one PERCODAN tablet usually brings relief within 5 to 15 minutes and maintains it for 6 hours or more. It rarely causes constipation.

Average Adult Dose—1 tablet every 6 hours.

Precautions, Side Effects and Contraindications—The habit-forming potentialities of PERCODAN are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias.

Also available: PERCODAN®-DEMI, each scored pink tablet containing 2.25 mg. oxycodone HCl (Warning: May be habit-forming), 0.19 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.19 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

roughout the wide middle range of PAIN...

you can rely on PERCODAN®

Each scored yellow PERCODAN* Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

*U.S. Pats. 2,628,185 and 2,907,768

Literature on request

ENDO LABORATORIES INC. Garden City, New York

IMJ

Illinois Medical Journal

CONTENTS

volume 129, no. 5 *May, 1966*

MEDICAL PROGRESS

The Paraproteinemias
Robert S. Griffin, M.D. and Steven O. Schwartz, M.D., Chicago 561

CLINICAL ARTICLES

Cases of Lymphoma Treated With Human Tissue Antisera
Irving Greenspan, M.D., Skokie 549

Acutely Obstructed Incarcerated Paraesophageal Hernia
Sidney W. Raymond, M.D., River Forest 556

Home Care Association of St. Clair County
Willard C. Scrivner, M.D., East St. Louis 558

The View Box
Leon Love, M.D., Chicago 567

Depressive Anorexia
S. H. Kraines, M.D., Chicago 569

Some Thoughts on Longevity
N. Gilmore Long, M.D., Chicago 573

An Analysis of the Opinions Toward Mental Health Among Nurses and Physicians in DeKalb County, Illinois
Irving Frank, M.D. and Marvin Powell, Ph.D., Sycamore....579

Melanoma Masquerading as a Psychosomatic Disorder
John C. Kulis, M.D., Chicago 582

David Prince, Pioneer Surgeon
Frank B. Norbury, M.D., Jacksonville 584

Results of "Operation Head Start" in Chicago
Harvey Kravitz, M.D., Chicago 590

FEATURES

President's Page 532
Editorials 593
℞ Reviews and New Products 604
Meeting Memos 616
Placement Service 617
News and Announcements 618

Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Ill. 60601. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.50 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies available at cost of 75 cents. Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.
Copyright 1966, The Illinois State Medical Society.

An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus... Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

TAO®
[triacetyloleandomycin]

J. B. Roerig and Company, New York, New York 10017
Division, Chas. Pfizer & Co., Inc., Science for the World's Well-Being®

TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylocci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References:** 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science **1**:185-256 (July-Aug.) 1964.

The president's page



Burtis E. Montgomery, M.D.

A LOOK BACKWARD AND A LOOK AHEAD

As this is the last opportunity I will have to exercise the prerogative of utilizing a page in the *Illinois Medical Journal* to greet you, I want to take this means of letting you know what a great privilege and honor it has been for me to serve as your president during the past year. As I have traveled around the state, I have met hundreds of doctors that I would not otherwise have met and I feel that I have come to know many of you well. This has been not only a personal pleasure, but very helpful to me as an officer of your society trying to represent you and your thinking at times when policy is made for the operation of organized medicine. You, in turn, have been extremely helpful in making your feelings known and your hospitality, as I have visited with you in your own areas, has been most welcome.

I know that I can depend on each of you to show Dr. Portes the same courtesies and cooperation that you have given me this year.

By the time you read this, our own annual meeting will be behind us and we will be looking forward to the next big event on the medical calendar—the annual convention of the American Medical Association June 26-30 at McCormick Place in Chicago. As you know, we will act as hosts at this important affair, and we hope to see many of you in attendance. As part of this function, Illinois will give a luncheon on the 27th at the Palmer House and will maintain a hospitality suite at the hotel throughout the week.

Your delegates, as usual, will endeavor to become as informed as possible about the business of the convention so that they can represent the Illinois State Medical Society and its individual members conscientiously at the national level.

As members of the AMA, you, of course, should feel free to visit the House of Delegates during the convention and participate in reference committee hearings. This is a fine opportunity for all members of the Illinois society to see how the AMA is operated, observe the House in action and, as individuals, to be heard in the committee hearings.

Thank you so much; it has been a most rewarding experience and I look forward to seeing all of you often in the future.

IMJ

Illinois Medical Journal

volume 129, number 5 May, 1966

CASES OF LYMPHOMA TREATED WITH HUMAN TISSUE ANTISERA

Irving Greenspan, M.D./skokie

Patients with Hodgkin's granuloma and chronic myelogenous leukemia responded favorably to treatment with "specific" hyper-immune serums, one which was prepared from a patient's diseased lymph node extract in a human volunteer. Present immunologic data substantiates our previous work which showed that diseased tissue extracts elicit a highly specific antibody. The use of chemotherapy to destroy rapidly multiplying malignant cells, and "specific" immune antibody to prevent further production of malignant cells and residual viremia, was undertaken as a practical approach to arrest these lymphomas. These cases are of interest because two of the patients are now able to maintain normal hematological, roentgenological and clinical signs as long as antibody is supplied at intervals of four to six weeks.

Case Number One

Patient M.S., when first seen in October, 1962, had had Hodgkin's granuloma for eight years. The patient had received maximum radiation, nitrogen mustard, and Cytoxan and was now leukopenic and refractory to chemotherapy. The patient had marked infiltration of both lungs and was dying a respiratory death. A generalized enlargement of the lymph nodes was found. The patient's WBC was 2,200. The occipital node behind the left ear measured with node calipers; 5mm. wide by 5.9mm. at its long axis and 4.7 mm. at its transverse axis. The left axillar node measured 4.5 mm. wide by 6.6 mm. long axis and 5.5 mm. transverse axis. Ten cubic centimeters of commercial gamma globulin was given into each buttock. After three weeks the nodes were noted to be slightly larger. Ten cubic centimeters of hyperimmune anti-Hodgkin's gamma globulin, prepared by injecting rabbits with a cell free filtrate from human Hodgkin's diseased nodes,[4] was injected into each buttock. In seventeen days the WBC was 4,400 and the left

Chief of Lymphoma Research Institute, Lutheran General Hospital, Park Ridge, Illinois.

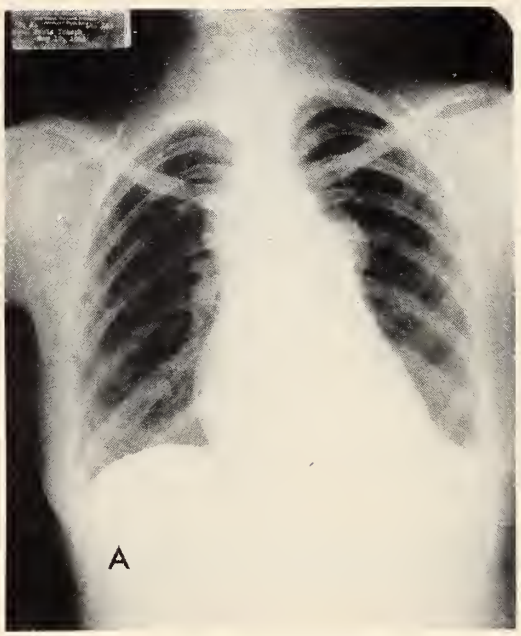


Figure 1: (April, 1861) The two meter p. a. film of the chest demonstrates moderately severe symmetrical transverse enlargement of the cardiac shadow associated with well defined right paratracheal adenopathy and enlargement of the nodes in the projection field of the superior pole of the left hilum. The left hemidiaphragm and costophrenic angle are obscured by a left basal pleural effusion.

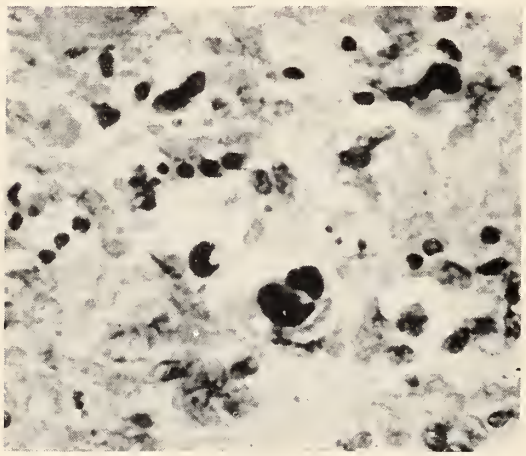


Figure 2: Lymph node: a variety of cells of Hodgkin's disease. Giant cell of Reed-Sternberg with bilobed nucleus, seen in the center of the field and numerous eosinophils infiltrating the field.

ear node measured 3.1 mm. by 4.6 mm. by 3.8 mm., and the left axillar node measured 3.6 mm. by 3.9 mm. by 4.6 mm. Her skin was marked with dye and the same identical areas were measured by the precise calipers. The patient was admitted to Louis A. Weiss Memorial Hospital and succumbed to respiratory failure. More specific sera was not available for the patient's immediate use.

Case Number Two

In November, 1962, patient S. S. had the following findings: a WBC of 168,000, enlarged liver, and spleen 4 cm. below the costal margin. The bone marrow and peripheral smears were compatible with the diagnosis of chronic myelogenous leukemia. Human, cell free, leukemic, reticuloendothelial tissue extract, made sterile and inactivated, as described by Greenspan, Brown and Schwartz,[2] was injected into volunteer prisoners and the resultant, recovered, pooled gamma globulin, made by a modified Cohn method and lyophilized, was given to the patient. This specific sera was tested in mice and prevented the induction of murine leukemia in 70-80% of the susceptible mice, as compared to controls not receiving sera prior to their injection of virulent antigen.

The patient was given 20 cc. of the "specific" antileukemic gamma globulin containing 5 mg./cc. once weekly between November 26, 1962 and January 3, 1963. The patient was observed for four weeks before medication and her WBC averaged 168,000. By January 3, 1963, the WBC fell to 77,000, with marked improvement of the immature forms in the differential smear from 40% to 10%. The supply of the "specific" human gamma globulin was exhausted, and four weeks later the count was back to 229,000, with 60% immature forms. Urethane, 1 tablet t.i.d., was started and the dosage increased to 2 tablets t.i.d., and in March, 1963, the count dropped to 24,300. Urethane was then used until September, 1964, but in the last six months the count gradually increased, the spleen enlarged, and Urethane was abandoned for Colecimide tablets, 1 t.i.d., producing a drop in WBC and increasing the patient's sense of well being. In October, 1964, the count had risen and the patient was bleeding internally, and splenic

enlargement had recurred. Myleran, 1 tablet b.i.d., was started and until February, 1965, the patient maintained a plateau. The patient's peripheral smear showed smudge cells, myelocytes 10%, and metamyclocytes 20%, with marked toxicity of the remaining cells. In February, 1965, we again secured from Cook County Jail a human supply of "specific" gamma globulin, and began using massive monthly doses of 20 cc. into each buttock, with Myleran reduced to one 2 mg. tablet per day. The patient has now maintained an average 6,800 WBC with all mature cells in the peripheral smear, and with complete reduction of the spleen to the costal margin. The patient's sera did not react with Hodgkin's disease node antigen or leukemic tissue extract, but now reacts to human Hodgkin's disease node antigen slightly, and strongly to leukemic antigen by passive cutaneous anaphylaxis, microprecipitin, and immunodiffusion tests. This is the longest period the patient has been clinically and hematologically well with the smallest dose of a chemotherapeutic agent.

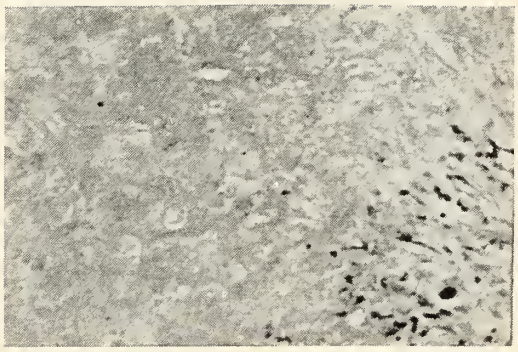


Figure 3: Different area of same lymph node showing marked areas of necrosis and early fibrosis.

Case Number Three

The third case was a twenty-six year old, white female who had a routine physical examination in March, 1961, with no abnormalities present. In April, 1961, the patient noted swollen cervical nodes. Firm nodes were found in the right supraclavicular region. Roentgenologic examination of the chest revealed large paratracheal nodes, pleural effusion on the left side, and marked cardiomegaly (Figure 1). The hemograph showed HBG: 10.4 gms., RBC: 4,480,000, WBC: 8,200, with a differential white cell count of 69 neutrophils, 1 band, 9 lymphocytes, 3 monocytes, 1 basophil, and 17 eosinophils. Liver and spleen were not demonstrably enlarged. The patient was admitted to Louis A. Weiss Memorial Hospital, April 24, 1961, for diagnostic work-up and therapy.

A biopsy of the right supraclavicular node revealed heavy eosinophilic infiltration, giant cells and areas of necrosis and fibrosis, and a presumptive diagnosis of Hodgkin's granuloma was made. The patient was placed on Cytoxan 50 mg. t.i.d., and pooled, commercial gamma globulin was given intramuscularly, 10 cc. into each buttock, and repeated in two weeks. The

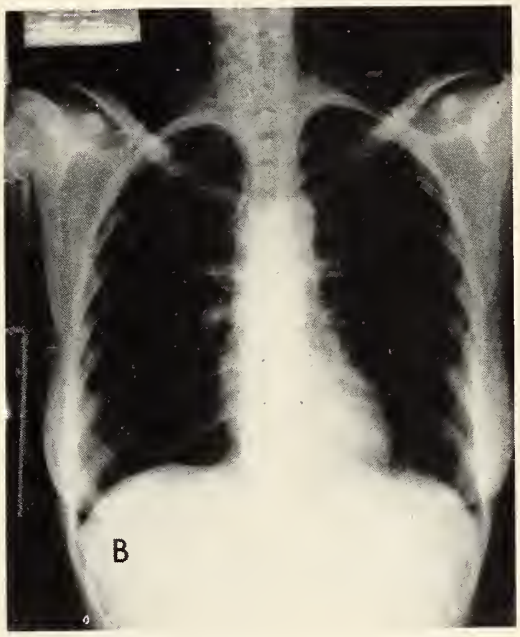


Figure 4: (December, 1961) The two meter p. a. film now demonstrates a normal cardiac silhouette, absence of mediastinal adenopathy and no evidence of pleural effusion. The chest is within normal limits.

patient had drenching sweats, marked prostration and increased lymphadenopathy. The patient's condition deteriorated and she was re-admitted to Louis A. Weiss Memorial Hospital on June 21, 1961, gravely ill. The nodes were enlarging and were again removed. Dr. Walter Dwiega, Pathologist at Weiss Memorial Hospital, and Dr. Henry Rappaport, Consultant to the Army Institute of Pathology, independently confirmed a diagnosis of Hodgkin's granuloma (Figure 2, Figure 3).

Specific Antibodies Produced

Earlier studies have shown that it is possible to produce specific antibodies in man to antigens obtained from leukemic tissue.[1] For this reason, a large portion of the biopsied node was fast frozen for use as an antigen. A sterile cell-free extract was prepared, as previously described.[2] The donor was immunized with cell-free sterile antigen prepared from patient's frozen node and given three injections, three weeks apart, 0.1 ml. intracutaneous, 0.9 ml. intramuscular. This material was tested in animals for infectivity and toxicity prior to the volunteer's injection. The development of antibodies to the material was demonstrated in his serum by passive cutaneous anaphylaxis, microprecipitin and immuno-diffusion tests. The donor's serum gave a positive reaction to leukemic antigen, as well as to Hodgkin's diseased node, and was protective to mice injected with murine leukemic antigen, same as convalescent leukemic mouse serum.[2, 3]

The donor's serum was negative to other carcinoma and viral antigens. The donor's serum, prior to immunization, was negative to all tests and non-protective to the same breed of mice.

The patient's serum was negative for antibodies to Hodgkin's diseased node or leukemic tissue extracted antigen. In July, 1961, the patient was given Cytoxan 50 mg. t.i.d. After three weeks, severe nausea developed and dosage was reduced to 50 mg. per day. There was no appreciable change in the chest roentgenograms or the cervical nodes from July to September, while on Cytoxan and commercial gamma globulin. In early December, 1961, 40 cc. concentrated gamma globulin was extracted from the donor's serum and given to the patient. The Cytoxan was continued as before. By the end of December, 1961, there was a marked change in cervical and paratracheal nodes (Figure 4).

Later attempts at active immunization with the patient's own node material seemed to flare up the entire process, producing enlarged nodes and consuming the remaining material, which was used to make antigen to inject the donor. By May, 1962, while on Cytoxan but not on gamma globulin, a rapid enlargement of both cervical and paratracheal nodes occurred.

Again, no antibodies to Hodgkin's disease node antigen, as in the beginning, could be demonstrated in the patient's serum. It was decided that if reversal of the malignant process was to be accomplished, a continual dose of the prepared gamma globulin would have to be used. It would be interesting to see if "specific" gamma globulin, for the second time, could reverse the rapidly advancing malignancy.

Material for Further Stimulation

The patient was re-hospitalized and more nodes were removed from both cervical areas in order to obtain material for further stimulation of the donor. After re-stimulation, gamma globulin was again prepared from the donor's plasma, and the patient was given a calculated dose (20 cc. to 40 cc.) in May and again in June. By the end of July, 1962, the hilar lymph nodes and cervical nodes again regressed significantly, and new antibodies could be demonstrated in the patient's serum to Hodgkin's disease node. From August through November, doses (20 cc.-100 mg.) of this "specific" gamma globulin were given to the patient monthly. No determined dosage was ascertained for maintenance at this time. Further injections were discontinued in December, when the patient seemed to be in clinical remission, and it was hoped that her own reticuloendothelial system might continue to make antibodies.

In February, 1963, the patient developed a cervical lymph node on the right side. She was given a large dose of gamma globulin (300 mg.) in March and in April, with regression of the node. From that time until September, 1964, the patient received monthly injections of gamma globulin (300 mg.) and 50 mg. Cytoxan per day, and remained in excellent health and hematologic remission. In each relapse, lymphocytes fell to 0-10% and eosinophils rose

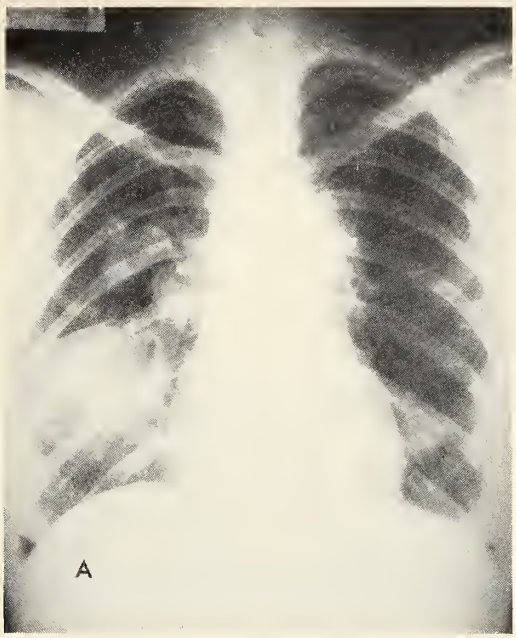


Figure 5: (August, 1964) The two meter p. a. film of the chest demonstrates mild to moderate symmetrical transverse enlargement of the cardiac shadow which is associated with bilateral hilar and mediastinal adenopathy and homogeneous opacification of the right middle lobe with segmental areas of opacification involving the right upper lobe. Pleural reaction is again noted in the left lung base. The calcific foci seen at the periphery of the left midlung field were present on the initial examination and are unchanged.

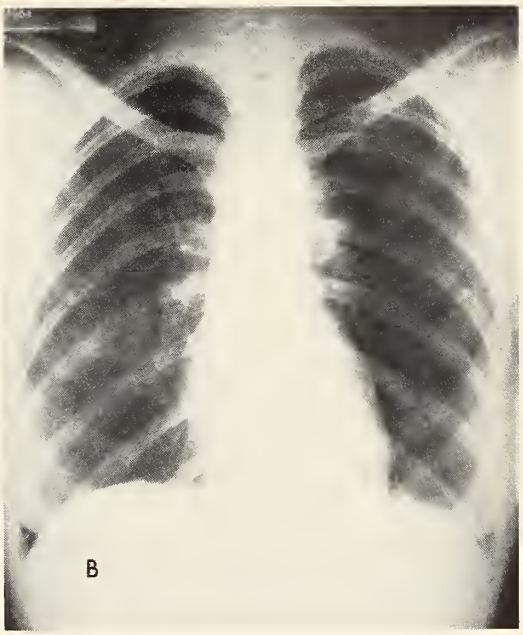


Figure 6: (November, 1964) The two meter p. a. film reveals almost complete resolution of all areas of opacification previously noted. There are residual fibrotic stands in the right midlung field at the level of the midportion of the eighth rib posteriorly. The hilar and mediastinal adenopathy is resolved. The hilar shadows show a non-specific prominence. The cardiac shadow is within normal limits as to size. The diaphragm is now tented by an adhesion adjacent to the left heart border.

from 10-17%. In each response to gamma globulin, the lymphocytes rose to 20-24% and eosinophils became insignificant, 2-4%. The donor received monthly booster injections of the antigen, previously obtained and frozen from the patient's third hospital admission.

In September, 1964, after being off Cytoxan for three months, and off gamma globulin injections for two months, the patient developed wheezing, fever, and cough. Radiologic studies, at this time, revealed a large infiltrative lesion in the left, lower, and the right mid and lower lung fields (Figure 5). All tests for bacterial and viral pneumonia were negative, and the patient failed to respond to all antibiotic therapy. Large doses of gamma globulin (600 mg. to 1 gm. total) were administered from September through November. It was feared the tumor might become refractory to the previously used gamma globulin or that the antigenicity might change and new specific antibody needed. However, the fever subsided and the patient felt well. Cytoxan was reinstituted at the end of November, as it was felt that newly formed malignant tissue would respond to chemotherapy and antibody synergistically. The small monthly doses of gamma globulin could also have resulted in the exacerbation of the disease. In mid-November, hematologic and roentgenologic studies, as evidenced by x-rays, returned toward normal (Figure 6). Thus, after twenty-four months on combined therapy, with the exception of this one flare-up, the patient has been in remission clinically, hematologically, and radiologically. This period coincides with the demonstrability of antibodies to Hodgkin's disease extract antigen, previously absent in her serum. The patient's serum, as well as that of the donor husband, reacts to Hodgkin's disease

antigen and less intensely to leukemie antigen in the battery of immunologie tests. The sera were negative in the patient during aetive disease, in the donor husband before immunization and, in both, negative to other careinomas and viral antigens. The diseased node antigen reacts with the patient's sera in remission and husband's immunized sera, some infeetious mononucleosis sera, and eonvaleseent mouse sera. The diseased node antigen is negative to commereial gamma globulin and a variety of sera from different careinomas; breast, esophagus and stomach, and various virus convalescent sera.

Comment

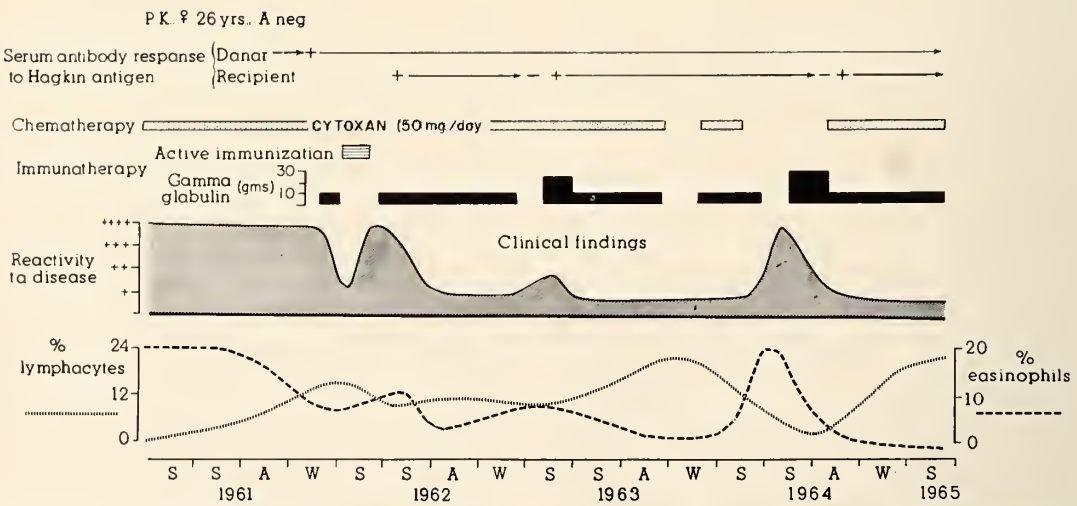
It is more than likely that ehemotherapy destroys rapidly multiplying malignant eells, and that specifie anti-viral antibody helped prevent formation of new malignant eells from infeeted eells by neutralizing virus existing in already malignant eells.

A dose of 50 mg. of Cytoxan per day is not likely to have produced the effeet seen in the last case presented, as four separate exacerbations oeeurred while on eontinued Cytoxan therapy. Prolonged periods of elinieal remission are common in Hodgkin's. However, the four distinet episodes of clinical exacerbation were reversed in this case by the use of "specific" immune gamma globulin, and therefore, it is believed a cause and effect relationship exists between the use of this "speeific" gamma globulin and the remissions. This same "speeifie" gamma globulin was seen by measurement to reduee the nodes in terminal ease one, after maximum radiation and chemotherapy had been given. It is further believed that the reason for the marked effectiveness of the "speeifie" gamma globulin in Case Three is the faet that antigen used to stimulate the produetion of the antibody was the patient's own, and the donor husband had the same blood type as the patient (Chart). The "specifie" gamma globulin was not only antiviral, but also anti-cellular, as the antigen prepared eould have produeed both types of antibody. The small dose of ehemotherapy aeted synergistically with the antibody against the multiplying malignant cells.

The seeond ease typifies the synergistic aetion of small doses of ehemotherapeutie agent and specifie antibody where large doses of chemotherapy, no therapy, or small doses of antibody did not eontain the patient's disease.

The question of the ability of the body to produce its own antibody is important, otherwise a lifetime of passive therapy would be neeessary. Early in Cases Two Three it was not possible to demonstrate antibody, presumably beeause the patient's own retieuloendothelial system was inadequate to the task.

In patient Three, stopping passive im-



The chart illustrates the four separate exacerbations which responded to specific gamma globulin, promoting clinical remission, as well as positive hematologic change. Active immunization causes specific flare-up of the disease. Cytoxan, by itself, did not hold the disease in check. Combination therapy produced the best remission.

munization and chemotherapy resulted in another severe exacerbation of the disease. Large doses of "specific" gamma globulin caused a significant reversal of the disease. Both patients' (Two and Three) own ability to be immunologically competent is not yet demonstrated. The cessation of gamma globulin induced exacerbation because of rapid replication of virus thus forming new malignant cells, may explain why chemotherapy alone will hold a remission for only a period of time. The antigenicity of the malignant cells or virus within them may change necessitating a new specific antibody complex to arrest their progress. In Case Three, by giving more highly specific concentrated antibody over a long period of time, the patient's own immunologic defense might become active in her complete recovery, involving a reversal of immune paralysis due to the reduction of the viremia to the point where the patient's reticuloendothelial system can react with her own specific antibody production. It is conceivable that small doses of immune gamma globulin can act as excitor. The likelihood that an inbred immunologic deficiency exists in lymphomas, per se, would indicate that supplying "specific" antibody in proper dosage will continue patient's stability, much like insulin to a diabetic, and that this method of therapy should be explored further, due to the immunologic data accumulated in these cases, and extended to a valid series with adequate controls.

Summary

Three cases of lymphoma treated with prepared immune "specific" gamma globulin showed a variety of response. Case One, preterminal, had already had maximum radiation and was refractory to chemotherapy, responded to "specific" gamma globulin with node reduction, but succumbed to the disease. Case Two treated with immune gamma globulin made an excellent response in WBC reduction, followed by failure when small doses of gamma globulin or various chemotherapeutic drugs alone were used. When small doses of chemotherapeutic drugs and adequate "specific" immune gamma globulin were given, this patient went into remission, which lasted nine months to date.

Case Three was treated by a combination of small doses of Cytoxan and "specific" immune gamma globulin obtained from a volunteer, who had been injected with material obtained from the patient's Hodgkin's disease involved lymph nodes. The patient had four clinical exacerbations, which were reversed each time by the gamma globulin treatment. At this time, the patient is clinically free of disease and is showing antibodies against her disease. It is postulated that the diseases of patients Two and Three are being held under control by the "specific" gamma globulin, which tends to hold viremia at a level where new malignant cells cannot be produced, and chemotherapy and "specific" gamma globulin significantly have reduced existing malignant cells.

The data in these cases supports the idea that lymphoma is a viral disease and that a combination of "specific" immune antibody and chemotherapy may promote a status quo prolongation or eventual cure of the disease.

Acknowledgments

The author wishes to acknowledge his indebtedness primarily to Eric R. Brown, Ph.D. whose diligent work, technical help, and fractionation of the gamma globulin made these studies possible. To the Cook County Jail and Warden Jack Johnson for their cooperation. Seymour Greenspan for technical assistance; Leon B. Barbrow, M.D. and Arthur Schwartz, M.D. for x-ray and surgical assistance at the Louis A. Memorial Hospital; Irving Friedman, M.D. for research drugs; Joseph King, M.D. and Fred Madenberg, M.D. for referral of patients; and Mrs. Edna Weeks for the preparation and editing of the manuscript.

References

1. Greenspan, I. and Schwartz, S. O.: Demonstration of Specific Antibody Reaction to Leukemic Tissue Extracts (Proc. Amer. Assn. Cancer Res. 3:230, 1961).
2. Greenspan, I., Brown, E. R., and Schwartz, S. O.: Immunologically Specific Antigen in Leukemic Tissue. Blood 21:717, June, 1963.
3. Greenspan, I., Brown, E. R., and Schwartz, S. O.: Antibody Response of Mice to a Leukemogenic Virus. Nature, Vol. 202, No. 4935, pp. 916-917, May 30, 1964.
4. Garb, S., Stein, A. A., and Sims, G.: The Production of Anti-human Leukemic Serum in Rabbits. *Journal of Immunol.* 88:142-152, 1962.
5. Raffel, S.: Immunity. New York, Appleton-Century-Crofts, Inc., 1961. pp. 580-581.

ACUTELY OBSTRUCTED INCARCERATED PARAESOPHAGEAL HIATAL HERNIA

Sidney W. Raymond, M.D./river forest



Appearance of incarcerated stomach and stretched out duodenum, two hours after the ingestion of barium meal.

In 1964, a comprehensive review of incarcerated stomach through a diaphragmatic hernia was published.[1] Because of the infrequency of the condition, and the fact that no cases have appeared in the English language literature since that date, the following description is offered

Case Report

A white female, eighty three years of age, entered the hospital with "gastric obstruction." Pertinent history showed a previous admission in 1961, when she was hospitalized for approximately one week. During her stay, a diagnosis of duodenal ulcer and hiatus hernia was made. Her blood findings at that time were within normal; her urine showed casts and pus cells; and x-rays showed a poorly defined gall bladder with the dye retained in the stomach. A large paraesophageal hernia, a distended stomach with narrowing of the pyloric antral portion, and deformity of the bulb with no gastric retention were found. An old fracture of the left femur was noted. The intestinal gas pattern was within normal limits. Conservative treatment was instituted and the patient was discharged in apparently good condition.

At this admission, May 15, 1965, her diagnosis was again gastric obstruction. There was slight mental confusion. A history of constipation, loss of appetite and vomiting for two weeks was elicited. No food and only small amounts of liquid had been ingested during that time. There had been no passage of gas or stool for twenty-four hours. Abdominal distention had been present for the past week. She was under therapy for high blood pressure; bilateral cataracts were present and there was a cardiac irregularity.

Examination revealed an obviously dehydrated individual with a distended abdomen. Tympany was present; no masses could be palpated; no tenderness was elicited; and bowel sounds were greatly reduced. Blood findings were within normal limits. The urine showed three plus protein, moderate pus and red blood corpuscles. Blood chemistries, except for potassium being 3.4, were within normal limits; blood urea nitrogen was 25.0 and the CO_2 content of the blood 26.0. X-rays, made on entrance, showed a completely thoracic stomach with almost complete ob-

struction due to torsion and the anomalous position. Two hour residue was ninety percent. The abdominal distention appeared to be of reflex origin. She had an abnormal electrocardiogram showing left ventricular hypertrophy with probable anterior septal infarcts (old). A Levine tube was inserted and dextrose in saline with potassium was given. Sixteen hundred cubic centimeters of fluids were recovered from the Levine tube within a few hours. She was restrained with a Posey belt; a Foley catheter was placed in the bladder; and barbiturates were given. Blood was made available for use in surgery.

The following day surgery was performed. The left hepatic ligament was severed and the left lobe of the liver was displaced to the right. The liver was cyanotic. The stomach, with a stretched out first portion of the duodenum, was replaced within the peritoneal cavity. The hiatal opening was closed with interrupted silk sutures, the anterior wall of the stomach was sutured to the under surface of the diaphragm and the abdominal wall with the same material. Patency of the pylorus was determined and the abdomen was closed using chromic catgut and silk.

Post-operatively, Levine drainage was continued. On the second post-operative day, much gas with some stool was expelled. Diet was started as soon as patient was able to swallow. A prophylactic dose (150.00 mg.) of Dicumerol was given on the second post-operative day and Maalox, which the patient had been using elsewhere, was continued as desired. Ambulation was started the day after surgery.

Seven days post-operatively a sero-sanguinous purulent discharge took place from the wound. There were mild psychic disturbances. The patient became dyspneic and developed pain in the chest and it was believed that cardiac failure was taking place. Cultures of the wound showed mixed bacteria which were sensitive to practically all antibiotics. Erythrocin was given. Dicumerol therapy was intensified. The legs had been previously bandaged. Electrocardiograms showed anterior septal infarct with ischemia. Warm wet packs were applied to the abdomen and the patient was confined to bed with oxygen.

Deterioration took place for several days and ACTH with hydrocortisone was given. There was a rapid improvement in the infection and the general condition started to improve. After five days, antibiotics were stopped and chemotherapy started. Two weeks after her heart attack she was able to be up in a chair and the abdominal wound was healed. Additional recovery was rapid and on June 26, 1965, the patient left the hospital.

Summary

A single case report is added to the literature of incarcerated diaphragmatic hernia. Treatment of this unusual condition is reduction of the incarcerated viscus, partial closure of the hiatal opening, and anchoring of the stomach, preferably by abdominal approach.

Reference

1. Shocket, Everett, et al. The Acutely Obstructed Incarcerated Paraesophageal Hiatal Hernia. *Am. Journ. Surg.*, Dec. 1964, p. 805.

THE IMPORTANCE OF DRUG ADVERTISING

The importance of the advertising industry in the economic development of our country is well-recognized and, more specifically, in the development of use of new and better drugs. Practicing physicians receive a substantial part of their education concerning drugs through the medium of prescription drug advertising. This indeed, is basic and underlies the Federal law which places responsibility on the advertising industry to present factual and undistorted information to the physician. Furthermore, the prescription drug advertising provision of the law actually is a recognition of the importance of such advertising in the entire area of medical care in the United States.—Joseph F. Sadusk, Jr., M.D., *Current Therapeutic Research*, May 1965.

Home Care Association of St. Clair County

Willard C. Scrivner, M.D./east st. louis

In 1959, during the local planning for the White House Conference on Aging, it became apparent that there was a need for a coordinated home care program in St. Clair County. Three physicians, members of the St. Clair County Medical Society, assumed leadership in developing the program. With approval and encouragement by their local medical society, the three physicians held conferences with Mrs. Lucille Tucker, Director, Visiting Nurse Association. Approval of their participation by their governing board was prompt in coming, and the preliminary organizational planning began immediately.

Basic Principles for Establishing a Homehelper Service

1. A major effort in behalf of the total problems experienced by the aged, but inclusive of the following additional aims.
2. To assist in the early recovery and rehabilitation of the sick.
3. To hasten convalescence and to reduce the length of stay in an institution by permitting the patient to remain at home or to return home sooner than he otherwise could. This will free hospital and nursing home beds for those who most need them. For the family, the individual, and the community, it will also help offset the cost of expensive institutional care.
4. To lessen the burden of chronic illness physically, mentally, emotionally, and economically.
5. To enable the individual whenever possible to remain in his own home among familiar surroundings.
6. To keep the family together while the natural homemaker (usually the mother) is incapacitated, whether she is in or out of the home; and to prevent family breakdown for any other reason, thus avoiding the shock of separating children from their parents, their brothers and sisters, their schools, and their friends.
7. To keep on his job the employed adult who now so often must take time off to care for children, an elderly parent, or an ill relative.
8. To help assess family and individual needs so that the family and Home Care Association may determine what plan will serve the best interests of the family and the community.
9. To help teach adults and children better ways of management of day-to-day living, better methods of self-care.

A steering committee was enlisted to assist in the planning for a community-based home care program and in its organization.

A Medical Advisory Committee was appointed consisting of three doctors of medicine and one doctor of dentistry.

The committee determined that the home care program should be organized to cooperate completely with the Visiting Nurse

Association. The latter organization has offered office space to the home care program. The staff of the proposed program would consist of a coordinator and a part-time secretary.

Services available in the community before the establishment of the home care program consisted of those services supplied by the Visiting Nurse Association including nursing service and rehabilitation nursing. Some equipment was available. The George Washington Hi-Twelve Club made hospital beds available to patients.

Work Simplification Clinics

The St. Clair County Chapter of the Illinois Heart Association had conducted work simplification clinics. Diet consultation had been available on a very limited basis through the voluntary work of a dietitian and home economist. Special diet material is available to patients needing same. Recipes for low salt diets obtained from the St. Clair County Chapter of the Illinois Heart Association have been compiled in pamphlet form. This pamphlet contains many low salt recipes, seasonings for tastier food, and dos and don'ts for salt restricted persons. Requests for this pamphlet have been made by persons in various parts of Illinois as well as Wisconsin and Indiana.

The Steering Committee recommended a budget of $26,000 for a three-year pilot program. Applications were sent to various national voluntary health associations and foundations. Unfortunately, the response was discouraging. Eventually, a foundation offered to contribute $10,500 for the three-year program. The three physician members of the St. Clair County Medical Society contributed $6,000 toward the $10,450 developed through solicitation of interested citizens.

A member of the Visiting Nurse Association Staff was employed as the coordinator for the program. The program was patterned after the Peoria Home Care Program and Miss Dorothy Campbell, R.N., coordinator of that program, lent valuable assistance and advice in formulating the new program in St. Clair County. A social case worker was made available through the Illinois Department of Public Aid on a consultant basis. The social worker is available to the Visiting Nurse as a consultant, and works closely with the Home Helper.

Eleven member Board of Directors with representatives from medicine, law, banking, social service, and interested lay personnel. Medical Advisory Committee.

If a patient has been referred by someone other than the physician the coordinator immediately contacts the physician and receives his permission to accept the patient. Instructions for the care of the patient are then received from the physician. If the patient is in the hospital the coordinator visits the hospital to discuss the proposed home care with the patient, family and nurses. Provision is then made for the care at home including homehelper services if needed, necessary equipment, visiting nurse's care and rehabilitation nursing (coordinated with the Visiting Nurse Association) and other desirable services. Similar conferences are held at the patient's home if the patient is not in the hospital and home care services are requested. After home care services have started the coordinator makes periodical visits to the home to discuss the progress and further care with the patient, family and homehelper. Changes in the condition of the patient are always reported to the physician by the coordinator or the nurse from the Visiting Nurse Association.

Loan Closet Established

A loan closet was established as the result of additional gifts from individuals and volunteers. Equipment purchased and available on a loan basis without charge is as follows: Wheelchairs, walkers, walkerettes, commodes, crutches, canes, and other articles needed for the ill person; a total of 120 pieces of equipment.

A Medeolator Stimulator, an electric stimulation device, was purchased by Home Care and, with the permission of the physician in charge and under the direction of a registered physical therapist, the instrument is used extensively by the Rehabilitation Nurse. If equipment requested is not available from the loan closet, every effort to obtain access for the particular item is explored and Home Care has been helpful in referrals to patients for purchasing items needed.

The homehelper service has proven tremendously successful and, although out-

standing in its success, it does exist as a part of the whole home care program. Recruitments, screening and selections of prospective homehelpers were begun and the first class was organized in October 1961. The prospective homehelpers were required to be between the ages of 18 and 65; must have certificate of health from their own physician, and a chest plate which may be made without charge at the East Side Health District. Classes consisted of nine two-hour lectures given by physicians, nurses, clergy, home economist, and others. The homehelpers were recruited through churches and other groups. Four classes have been held, graduating a total of 50 homehelpers. At present there are 25 active homehelpers; there has been a big turnover. The homehelper program has been enthusiastically received and many patients have been allowed to remain in their own homes or return to their homes from the hospital earlier than anticipated as a result of the active homehelper program. The fee for homehelpers is $1.00 per hour plus transportation. Many individuals and families are unable to pay this amount and some funds have been made available to supplement the payments of homehelpers in approximately 20% of the cases.

The pilot program of the Home Care Association began operation July 1, 1961 and concluded June 30, 1964. The community realizing the success and importance of the program will continue to finance the home care program of St. Clair County by furnishing 40% of its next year's budget through United Fund and the remainder by an allocation from the Department of Health, constituting a total budget for 1965 of $9,700.

As the public learns more about the organization, more requests will result requiring the coordinator to be projecting her plans for the future with greater emphasis on rehabilitation for the patient, recruitment of homehelpers to facilitate care of the total patient, when desirable, in a family environment as one way to reduce medical costs.

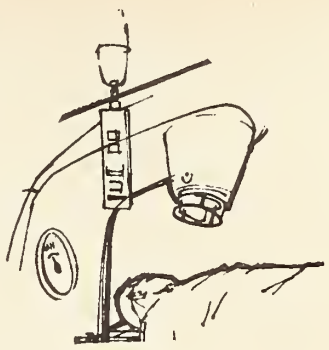
ENGLAND TODAY

General practitioners have reached the point where the burden of work has become intolerable. For the first time in my life I have heard responsible doctors raise their voices in complaint of their patients' thoughtless and even frivolous use of their services. And where this happens it is becoming impossible for general practitioners to provide the expert services they are able to provide. The really ill and the patient with early symptoms and signs of disease are bound to suffer. The circumstances of practice are driving good doctors out of the country and are a source of endless frustration to those who remain. It is stupid—and indeed irresponsible—to let political expediency and Party dogma stand in the way of a reform "that will encourage good general practice and responsible use of the N.H.S. by patients.

"Public policy on social welfare in Britain should long have been passing from preoccupation with the five or ten per cent relatively needy or irresponsible to the desires of the 90 or 95 per cent who are neither. But political conservatism in all parties and administrative inertia have tended to apply to both groups the same principles of equal State benefit paid for by compulsory insurance or taxation."

However exasperated doctors are with their often appalling conditions of work, I feel pretty sure they are not out to sabotage the Health Service. They recognize—and have recognized for a long time—that some kind of Health Service—or medical service, to be more accurate—is needed. But increasing centralization in the State medical services in modern Britain is killing initiative, holding up progress and reform, and introducing a note of bitterness in the relations between profession and public that I fear will worsen. Direct payment of money for services rendered is a well-tried and successful way of establishing a responsible relationship between a professional man and his clients. In Norway the profession itself decides the level of fees and the Norwegian doctors stick to it. The insured person will recover, say, 75 or 80 per cent of the fee from the insurance fund. *"Without Prejudice," British Medical Journal, July 17, 1965.*

Medical Progress



Harvey Kravitz, M.D./progress editor

THE PARAPROTEINEMIAS

PART I

Robert S. Griffin, M.D. and Steven O. Schwartz, M.D.

(A year and a half ago when compilation of this review was begun, we realized that at some point, time would have to call a halt to this effort even if its inevitable corollary, change, would not. This review, therefore, ends with the arbitrary date: July, 1965.)

PARAPROTEINEMIAS are a choice illustration of recent advances in hematology. This group of diseases, characterized by disordered protein metabolism, is represented classically by multiple myeloma and by macroglobulinemia of Waldenström. The study of the relatively pure proteins elaborated in large quantities in these two diseases has brought about better understanding of the chemical, genetic and clinical features of the paraproteinemias, and has permitted a more nearly complete characterization of normal globulins.

Appreciation of the rapid changes of concepts in this field calls for a reading comparison of the excellent clinical and biochemical reviews of Osserman[1] and Putnam[2] as set forth in 1959 and the resumés by Osserman,[3] Putnam,[4] and Franklin[5] in 1964. The information that was so competent in the 1959 publications appears incredibly superficial now.

Historical Development

The recognition of the paraproteinemias begins in 1845 with the description by Dr. Henry Bence Jones of an unusual type of "animal matter" in the urine of a 45-year-old tradesman with a disease of bone.[6] MacIntyre, in 1850, reported this patient's disease as "fragilitas ossium,"[7] a bone disease first described by Dalrymple in another patient in 1846.[8] The term *multiple myeloma* was coined by Von Rustizky in 1873;[9] Kahler, in 1889, was the first to suggest a relation between the bone disease *multiple myeloma* and the "animal matter," since referred to as Bence Jones protein.[10]

By a simple method of chemical fractionation, in 1921, Howe precipitated a protein from serum and called it *albumin*.[11] When

Department of Hematology, Hektoen Institute for Medical Research of the Cook County Hospital, Northwestern University Medical School and University of Illinois College of Medicine, Chicago.

this was subtracted from the total amount of serum protein, the globulin fraction was left. To this day, with minor variations, Howe's method of protein fractionation is depended on clinically even though this albumin fraction contains large quantities of globulin. In 1937 Tiselius separated the serum proteins in an electrical field according to the net surface electrical charge of the various fractions.[12] By this method of free or boundary electrophoresis, albumin, $alpha_1$ and $alpha_2$ globulins, beta globulin, and gamma globulin were eventually defined. Electrophoretic studies have now become routine in many laboratories as the result of techniques of paper electrophoresis developed by Turba,[13] Cremer,[14] and Durrum,[15] among others. On electrophoresis of sera from patients with multiple myeloma and macroglobulinemia a narrow "M" type globulin peak (M for myeloma and macroglobulinemia) can often be demonstrated which contrasts with the "broad" type of globulin increases frequently demonstrable in patients with cirrhosis, sarcoid, or chronic infection.

The Immunoglobulins

That antibody activity resided in the gamma globulin fraction of the serum proteins had been recognized since the work of Tiselius.[16] Because antibody activity could not be demonstrated for "M" proteins, even though electrophoretically they often migrated as gamma globulins, the term *paraprotein* was applied to these quantitatively, and probably qualitatively, abnormal proteins. Although most paraproteins migrated as gamma globulins, some of them resembled beta and, rarely, alpha globulins. By the technique of immunoelectrophoresis, developed by Graber and Williams in 1953,[17] the paraproteins migrating in the beta and $alpha_2$ areas have been demonstrated as gamma globulins. Also by the technique of immunoelectrophoresis, two other precipitin lines containing proteins with antibody activity have been identified in the beta region and labeled $beta_{2A}$ and $beta_{2M}$. These three globulins (gamma, $beta_{2A}$, and $beta_{2M}$), because of their common property of antibody activity, have been named *immunoglobulins*. This terminology is confusing, however, because the term *gamma globulin* has been used as a synonym for antibody. For this reason Waldenström suggested that although members of the immunoglobulin family might be located anywhere from the slow gamma to the $alpha_2$ regions on electrophoresis, they all be referred to as *gamma globulins* (gamma$_2$, gamma$_{1A}$, and gamma$_{1M}$). Perhaps the most reasonable nomenclature is that advocated by the World Health Organization (gamma$_G$, gamma$_A$ and gamma$_M$).[18] This terminology is followed in this article. Gamma$_G$ is so named because this is the protein residing primarily in the G (gamma) region. Gamma$_A$ and gamma$_M$ still convey the idea of common gamma globulin or antibody properties, and the letters A and M identify them with their synonymous terms. Recently, low molecular weight proteins antigenically related to gamma globulins have been observed in the sera and specimens of urine of normal persons.[19] These represent a fourth class (gamma$_U$) of immunoglobulins. The protein peaks in almost all plasma cell neoplasms are due to the overproduction of paraproteins having antigenic characteristics of any one of these classes of immunoglobulins — myeloma having gamma$_G$ or gamma$_A$ paraproteins in the serum, and Waldenström's macroglobulinemia having gamma$_M$ paraprotein. Both diseases may have peaks of gamma$_U$ paraprotein in the urine, and most, but not all, of these urinary proteins have the heat characteristics of Bence Jones protein.

Bence Jones Protein

Bence Jones protein was the first abnormal protein recognized in multiple myeloma. It is understandable that the study of this globulin should have been the most meaningful in furthering the knowledge about the immunoglobulins and the paraproteinemias. Bence Jones originally described urine that became turbid when acidified and heated, became clear on boiling, and turbid again on cooling. Through the years the test for Bence Jones protein has been refined to eliminate errors. The most reliable technique is given by Jacobson and Milner[20] who emphasize the following points: (1) only fresh or fresh frozen urine should be used for the test; (2) the urine should be centrifuged before testing; (3) precipitation at 45-60°C should be carried out at a pH of about 5 (using 2% acetic acid as necessary); (4) the pH

should be changed to 2-3 before boiling (by adding an equal volume of 5% sulfosalicylic acid); and (5) the urine should be diluted with normal urine if the precipitation at 45-60° is more than a 2+ reaction (to make sure that the Bence Jones protein will re-dissolve). This improved heat test for Bence Jones protein gives a minimum number of false reactions, and is positive in about 45% of cases of myeloma.

Although the foregoing test is useful as a screening procedure, electrophoresis of the urine is more productive, for not all of the diagnostic urine peaks of low molecular weight paraprotein have the heat characteristics of Bence Jones protein. According to Osserman,[1] a diagnosis can be made for 97% of patients with multiple myeloma by a combination of serum and urine electrophoresis; about 60% of such patients have a urine peak. Serum peaks have been observed in various lymphomas and carcinomas, as well as in myeloma, macroglobulinemia, and the recently recognized Franklin's disease.[3,21,22] Bence Jones type protein, however, is observed only in myeloma and macroglobulinemia, although a urine peak due to a protein without the physical properties of Bence Jones protein is present in Franklin's disease. The reasons for this become obvious after consideration of recent studies dealing with the antigenic and structural properties of the immunoglobulins ($gamma_G$, $gamma_A$, $gamma_M$, and $gamma_U$) and their related paraproteins ($gamma_G$ myeloma, $gamma_A$ myeloma, $gamma_M$ macroglobulinemia, and Bence Jones protein).

Antigenic Properties of Globulins

In 1956, Korngold and Lipari[23] reported that Bence Jones proteins could be divided into two antigenic types: I and II. Subsequently, Putnam,[24] Mannik and Kunkel (1962),[25] by using antisera prepared against types I and II Bence Jones protein, showed that the paraproteins from patients with myeloma and macroglobulinemia shared the type I and II antigenic determinants of Bence Jones protein. Fahey has since shown that normal immunoglobulins have the same antigenic makeup.[26] It is apparent then that each paraprotein and normal immunoglobulin (with the exceptions of Bence Jones protein, the Franklin protein, and $gamma_U$ globulin) has at least two types of antigenic specificity. One of these is class specific and accounts for the separate lines of precipitation for $gamma_G$, $gamma_A$, and $gamma_M$ on immunoelectrophoresis (reacting antisera prepared against human globulins with normal sera or sera from patients with myeloma or macroglobulinemia). The other is common to all and is the reason that each shows either type I or type II Bence Jones activity when reacted against antisera prepared against each of the two specific types of Bence Jones protein. However, in respect to this reaction, normal immunoglobulins differ from the paraproteins. $Gamma_G$ globulin from a normal person is a mixture of about 60% antigenic type I and 40% type II. Similarly, normal $gamma_A$ and $gamma_M$ are mixtures of types I and II in a ratio of about 2:1. In contrast, as might be predicted from the sharp peaks which are diagnostic on electrophoresis, the relatively homogeneous proteins present in patients with myeloma or macroglobulinemia are always either 100% type I or 100% type II.

Structure of Globulins

Structural explanations of the antigenic properties discussed have resulted from work initiated by Porter,[27] who employed limited enzymatic cleavage of rabbit antibody by papain, and Edelman,[28,29,30] who employed reductive cleavage of myeloma globulins. Porter demonstrated that rabbit antibody could be separated into three fragments. Two of these were identical (I and II) and were shown to have the ability to combine with specific antigen. Fragment III did not possess the antigen combining property, but, in contrast to fragments I and II, exhibited certain biologic activities (complement fixation, skin fixation, placental transfer). Applying the same type of enzymatic cleavage to $gamma_G$ myeloma globulins, Franklin[31] produced fragments functionally similar to the Porter pieces, and termed them A and C (Porter pieces I and II), and B (Porter piece III). Edelman,[32] separated the fragments according to their relative mobilities on immunoelectrophoresis. The F (fast) fragment was similar to Porter piece III (Franklin B), and the S (slow) fragment similar to combined pieces I and II (Franklin A and C).

It has since been shown that Bence Jones type I or type II determinants (common to all normal immunoglobulins and paraproteins) reside in the S fragment, suggesting that the same basic S fragment structure is common to all these globulins. As might have been predicted, the class specific determinant ($gamma_G$) was found to reside in the F fragment, suggesting that the F fragment of each type of gamma globulin is structurally different from all others.

By reductive cleavage of $gamma_G$ myeloma globulins, Edelman[28,29,30] obtained two kinds of polypeptide chains which were different from the S and F fragments. The lighter (L) chain, with a molecular weight of about 22,000, was similar to the Bence Jones protein of the same patient in many respects (antigenic properties, amino acid composition, peptide mapping). This led to the postulate that Bence Jones protein (molecular weight 45,000 and sedimentation constant 3.5) is a dimer of L chains (molecular weight 22,000 and sedimentation constant 2). The H chains (molecular weight 50,000) were completely different from Bence Jones protein. Porter then proposed a model for the structure of the gamma globulin molecule.[33] Although this model was constructed on the basis of information acquired from the study of $gamma_G$ globulin, it has been used as a tool for constructing models of all the immunoglobulins, even though reductive and enzymatic cleavage of $gamma_A$ and $gamma_M$ globulins has given inconsistent results. It has been suggested that each gamma globulin molecule consists of two identical L chains and two identical H chains. The H chains, with properties similar to those of F fragments, are completely different from one type of gamma globulin to the next, and account for individual class specificities. However, there are only two types of L chains, and either one of these two types may be present in any one molecule of any of the immunoglobulins or paraproteins. Since Bence Jones protein is a dimer of either type of these same L chains, then the basis for the property of Bence Jones typing common to all these proteins is obvious.

Franklin's Disease

If Bence Jones protein represents the production of L chains in excess of H chains, then it might have been predicted that occasionally an excess of uncombined H chains might also be produced. Franklin's disease, described in 1964,[34,35] seems to represent just such a situation. In this disease, which clinically resembles lymphoma more than myeloma, an excess of a unique type of globulin appears as a peak simultaneously in the serum and in the urine. The urine and serum proteins are identical; they do not have the heat properties of Bence Jones protein, and do not lend themselves to Bence Jones antigenic typing. This suggests that the protein represents an overproduction of a part of the gamma globulin molecule not containing an L chain. The disorder was named "heavy chain disease" to contrast with "light chain disease" (Bence Jones proteinuria), although actually the protein is more closely related to the F fragment of $gamma_G$ globulin than to complete heavy chains.

The Franklin Protein

The Franklin protein has a molecular weight of 53,000 compared to 45,000 for Bence Jones protein and 69,000 for albumin. This might partly explain its ability to pass through the glomerulus of the kidney easier than albumin can, but not so readily as Bence Jones protein (which is cleared so rapidly by the kidney that it cannot be demonstrated in the serum except by extremely sensitive immunochemical techniques). Since the Franklin protein is a sub-unit of $gamma_G$ globulin, it has been suggested that in time other heavy chain diseases will be disclosed having corresponding sub-units of $gamma_A$ or $gamma_M$ globulins in the serum and urine. This may not be true, however, for so far artificial cleavage of $gamma_A$ and $gamma_M$ globulins has been relatively unsuccessful in producing fragments similar to those produced from $gamma_G$ globulin. Furthermore, class specific fragments of $gamma_M$, even if formed in excess, might, because of their size, be detectable only in the serum. This is not to say that size alone determines the ability of a globulin to pass through the glomerulus or any other structure; substantial evidence suggests that size alone is not the only factor determining such passage. For instance, large amounts of $gamma_A$ globulin may be in the urine of normal persons, whereas only small amounts of the relatively same-sized

gamma$_G$ can be found. In man, as well as other animals, gamma$_G$, in contrast to gamma$_A$ and gamma$_M$, passes through the placenta. And in rabbits, although F fragments of human gamma$_G$ globulin injected into the uterine cavity passes into the fetus, the lower molecular weight S fragment and Bence Jones protein fail to pass.[5]

Chemical Studies

Chemical studies[4,36] support the model of the immunoglobulins constructed from their antigenic and biologic properties. Fingerprints of Bence Jones protein and L chains of the myeloma globulin from the same patient are almost identical. Each Bence Jones protein is unique in its amino acid sequence, as might be expected, for no two myeloma proteins or Bence Jones proteins from different patients are alike. However, Bence Jones proteins from different patients having all type I determinants have many spots in common on peptide mapping, whereas maps of type I proteins do not have any spots in common with type II maps. Fingerprints of Franklin protein are totally different from those of Bence Jones protein, but are highly similar to those of the class specific F fragment of gamma$_G$ globulin.

Globulin Production

That globulins are produced by plasma cells has been accepted for many years. Initially this relation was taken for granted because of the observed direct correlation between the levels of gamma globulins in the blood and the numbers of plasma cells in the marrow specimens of patients with hypogammaglobulinemia, reactive hyperglobulinemia, and the paraproteinemias. Martin furnished more direct evidence of this relation when, in 1947, he extracted a protein from a plasmacytoma and showed that it was identical on ultracentrifugation with the abnormal protein present in the patient's serum.[37] Vasques in 1958,[38] using the technique of immunofluorescence, confirmed the presence of gamma globulin in plasma cells. But Sonnet demonstrated (1958)[39] that myeloma proteins are actually formed by the plasma cells and are not merely deposited in them. Sonnet was able to produce myeloma protein in vitro by culture of plasma cells from the blood of a patient with plasma cell leukemia. The formation of Bence Jones protein by plasma cells was proved by Meyer[40] in 1957. He used C-14 labeled lysine in a culture of plasma cells from a myeloma patient to produce C-14 tagged Bence Jones protein identical to the protein observed in the patient's urine.

Myeloma Proteins

It seems logical to assume that different types of myeloma proteins might be produced by distinct types of plasma cells. In all earlier work in which myeloma proteins were classified according to their electrophoretic mobility, a correlation between cell type and serum protein could not be made, despite frequent assertions to the contrary. This would be expected when one considers that electrophoretic mobility depends strictly on physico-chemical properties and realizes that no two myeloma proteins are identical regarding their molecular size and structure. Using immunoelectrophoresis, however, some rather consistent correlation between cell morphology and type of protein produced has been observed. The best example was described initially by Paraskevas[41] and later confirmed by Drivsholm.[42] Working independently, they demonstrated that the marrows of patients with gamma$_A$ type myelomas, in contrast to other types of myelomas, almost always contained significant numbers of flame cells, thesaurocytes, and plasma cells with intranuclear inclusions. Flame cells are plasma cells in which part or all of the cytoplasm is acidophilic. Thesaurocytes are large plasma cells with small pyknotic nuclei and homogeneous greyish cytoplasm divided into compartments by thin, thread-like basophilic trabeculae. Intranuclear inclusions could be observed occasionally in other types of myelomas, but in those cases the intranuclear inclusions were always PAS negative in contrast to the PAS positivity of the carbohydrate-rich inclusions of gamma$_A$ myeloma.

It is well known that plasma cells elaborate gamma globulin; it is less well recognized that cells looking like lymphocytes can also produce gamma globulin. Thus, gamma$_M$ globulin may be present in increased amounts in patients with chronic lymphocytic leukemia, lymphosarcoma, and Waldenström's macroglobulinemia in the absence of any increase in plasma cells.

Moreover, it is known that newborns are able to make gamma$_M$ antibodies at times when few, if any, plasma cells are present in the marrows. Furthermore, increased titers of gamma$_M$ globulins may develop in patients with agammaglobulinemia without plasma cells at all in response to infection. In all cases of immunoglobulin production in the absence of significant numbers of plasma cells, the numbers of lymphocytes or lymphocytoid cells are always increased.

Plasmacytoid Lymphocytes

In patients with paraproteinemias other than myeloma, the cell type often cannot be classified. In patients with macroglobulinemia, the cells of the marrow, blood, and lymph nodes may look like typical lymphocytes. Oftener than not, however, the cells defy classification, and have been labeled *plasmacytoid lymphocytes* or *lymphocytoid plasma cells* to point up the combined features of lymphocytes and plasma cells in such cells. That such cells produce gamma$_M$ globulin has been shown by the use of C-14 labeled lysine in a culture of lymph node cells from a patient with macroglobulinemia.[43] Immunofluorescence has demonstrated that gamma$_M$ globulin is present in large and medium sized lymphoid cells, but not in the mature lymphocytes.

Electron microscopy has revealed fundamental differences in structure between the mature lymphocyte on one hand and the globulin producing lymphocytes and plasma cell on the other.[44] Globulin producing cells have cytoplasm filled to a variable degree with tubules of rough-surfaced endoplasmic reticulum (ER). The roughness is due to the presence of many ribonucleoprotein particles lining the tubules. These ribosomes release their protein into the tubules, and the tubules have actually been shown to contain gamma globulin. Ribosomes are also free in the cytoplasm and account for the basophilia of the cytoplasm. The Golgi zone may be involved in getting protein out of the cell. This zone does not contain ribonucleoprotein, and this accounts for the paranuclear clear zone or "Hof." A variety of cytoplasmic inclusions may be produced, depending on the degree of distention of the ER tubules and the type and concentration of the protein included. Mott cells, morula cells, grape cells, and Russell bodies are all explainable in this way. None of these inclusions is specific for the paraproteinemias, and any or all may be seen in the presence of disordered protein metabolism of any type. Many cells that look like mature lymphocytes on light microscopy may be seen to contain large amounts of endoplasmic reticulum on electron microscopy. A spectrum of cells may be seen from the lymphocyte with a small amount of ER to the plasma cell whose cytoplasm is completely filled with ER, suggesting that plasma cells may evolve from lymphocytes.

Normal Plasma Cell

The normal plasma cell is indistinguishable from the "myeloma cell" on electron microscopy. It is true that plasma cells in patients with myeloma often have bizarre shapes with multiple nuclei and distinct nucleoli, but such cells may also be seen in patients with reactive types of hyperglobulinemia, and occasionally even in normal persons. The occurrence of plasma cells in syncytium offers a more reliable sign for the diagnosis of myeloma.

Electron microscopy has not been of any value in helping to define the cause of the paraproteinemias. However, virus particles have been seen in mouse myelomas[45] and in one case of human myeloma,[46] and similar particles were also seen in the blood of Franklin's original patient with H chain disease.[47]

The Conclusion of "Paraproteinemias" Will Appear in the June Issue

(references available on request to the editor)

THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital



Figure 1.



Figure 2.

This 18-year-old boy entered the Cook County Hospital because of swelling of his left leg, left foot and both arms and hands. This had been gradually increasing all his life. His mother noted that as a baby his hands and left foot were large.

Physical examination revealed marked overgrowth of the soft tissues of his involved extremities.

What is your diagnosis?

1. Acromegaly
2. Neurofibromatosis
3. Lymphedema and elephantiasis

(answer on next page)

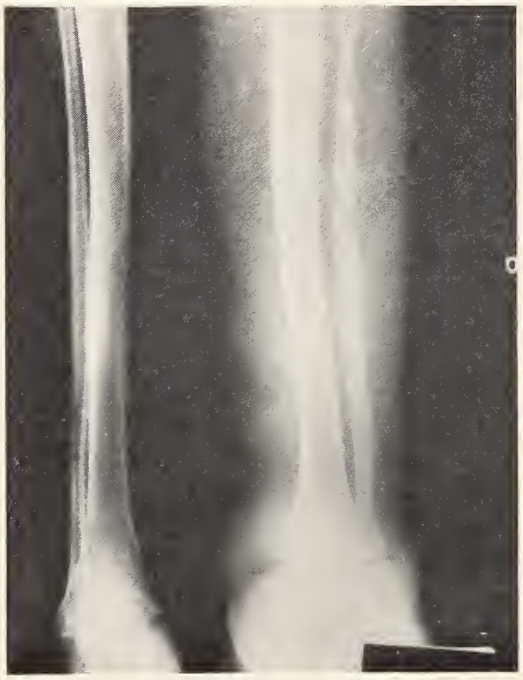


Figure 3.



Figure 4.

Diagnosis: Neurofibromatosis

Neurofibromatosis is a congenital and familial disease with widespread manifestations, such as lesions of the skin, tumors of the central and peripheral nervous system and abnormalities of bone. The diagnosis is obvious when there are multiple cutaneous neurofibromas associated with "café au lait" spots; however, these skin lesions may not be present and bizarre bone and soft tissue manifestations may be the presenting complaint.

Since it is difficult to explain the numerous bone abnormalities on the basis of nerve sheath tumors, it is believed that it is an associated mesodermal dysplasia with probable vascular involvement.

The bone changes may be: 1) kyphoscoliosis, 2) pressure erosion of bone by extension of neurofibromas into long bones, ribs, skull foramina, and spine, 3) hypoplasia of bone, 4) congenital bowing and pseudoarthrosis, 5) intraosseous radiolucent lesions, and 6) overgrowth of bone.

In our case, overgrowth was the predominant feature. It is usually associated with an elephantiasis-like enlargement of the overlying soft tissues. The soft tissue mass contains a diffuse plexiform neuroma, as well as hemangiomatous and lymphangiomatous elements. The affected extremity is increased in length. The bones may show a sinuous "S" shaped tortuosity. Irregular periosteal thickening occasionally occurs.

Reference

1. Hunt, J. C. and Pugh, D. D.: Skeletal lesions of neurofibromatosis. *Radiology* 76:1-20, January 1961.

Depressive Anorexia

S. H. Kraines, M.D./chicago

Anorexia is a primary presenting complaint in the endogenous, manic-depressive states. Endogenous depressions, which often masquerade as neuroses, are extremely common.

When anorexia occurs, and all other possible organic etiologic factors have been ruled out, then a diagnosis of endogenous depression[1] may be made upon examination of associated symptoms. The most common symptoms of such a depression are:

1. Anorexia
2. Insomnia with early awakening
3. Fatigue—present on arising
4. Blurred vision, tinnitus, a sense of unsteadiness
5. Psychosomatic symptoms—with intense "focused" fearfulness
6. Depressive mood—varying from boredom and sadness to deep melancholia
7. Loss of interest—in work, society, self
8. Phobias—particularly fears of insanity, of harming others
9. Difficulty in concentrating, in making decisions
10. Loss of sex desire
11. Wish to die—minimal (I'd rather not wake up again) to maximal (suicidal plans)

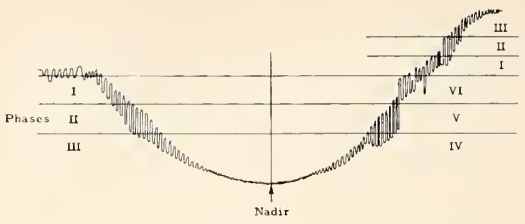
The classical depressive illness begins insidiously, often in the fall of the year. The typical cycle may be divided into six phases (chart I); the over-all duration of the illness varies from several months to several years. The intensity of the depressive reaction varies widely: in some patients, the curve may never drop much below phase I; in others, it may suddenly plunge to phase III and remain there for a long period of time. Finally, the depressive curve is not a smooth but a fluctuating line; the symptoms are alternately exaggerated or minimized.

Fluctuations in Appetite

In the endogenous depression, appetite fluctuates with the phase of the illness. In archetypal form,

in Phase I—the appetite is "finicky"
in Phase II—definite anorexia sets in, and
in Phases III and IV—anorexia becomes aversion
in Phase V—the physiologic appetite returns, initially for sweets, later for other foods; the "psychic" pleasure of appetite remains absent.
in Phase VI—the appetite fluctuates from moderate to excellent.

The patient's weight also follows a pattern. In the archetypal form, there is a gradual loss of weight (5 to 20 pounds) in phases I and II. Despite severe anorexia in phases III and IV, the weight level remains relatively stationary. In phase V, patients resume eating, often overeating, though without pre- or post-prandial enjoyment; the consequent gain in weight is



The Manic Depressive Cycle

Chart I

often greater than the original loss. In this phase, patients often complain, "I gain weight though I eat hardly anything." The rate of weight gain which is greatest in phase V, levels off to normal in phase VI.

There are many variations in appetite and weight loss. Some patients in acute depressions may lose over 40 pounds in the first month of their illness; others may lose a third of their initial body weight during a prolonged depression; some, in a prolonged fifth phase, may weigh a third more than at their pre-illness level.

Alimentary Tract Symptoms

Frequently in the depressive state, there are many associated alimentary tract symptoms: dryness of the mouth, a lump in the throat (spasm of the esophagus secondary to decreased secretion), epigastric distress, nausea and occasional vomiting, "gagging" sensations early in the morning (induced by brushing the teeth), constipation which in the fifth phase often alternates with diarrhea and is commonly diagnosed as spastic colitis. Hyperchlorhydria and aggravation of peptic ulcer symptoms often occur in the 5th phase. In the 6th phase, there is frequently bloating and a common complaint of abdominal "gas."

The etiology of the endogenous manic-depressive illness is unknown. A history of hereditary susceptibility is often found. The greater frequency of this illness in women, and the frequent onset of depressive states in the immediate post-partum period raises the suspicion of hormonal pathology as an etiologic factor.

These etiologic forces operate, as has been discussed elsewhere,[5] to produce hypothalamic physiopathology. Lesions in the ventromedial hypothalamic nucleus produce hyperphagia;[3] lesions in the lateral hypothalamic nuclei result in starvation[1] (chart II). The latter hypothalamic nucleus—the "feeding center"—is inhibited by the ventromedial nucleus; it has been shown via implanted electrodes, that amphetamines stimulate the ventromedial nucleus,[2] and presumably exert their appetite-inhibiting effect by this action.

The basic physiopathologic inhibition of the "feeding centers" may be modified by established habit patterns and by compensatory neurotic patterns. Many depression patients, though they have no appetite, continue to eat because of the force of habit—their weight is maintained. Many other patients force themselves to eat, "because one must eat to keep up one's strength." Many patients, highly neurotic, eat as a psychologic compensatory mechanism. In all these instances, despite the eating, there is neither appetite nor satisfaction.

Psychologic Therapy for the Complaint of Anorexia

As a rule, one does not treat the anorexia in depressive patients; one treats the basic illness: the cause not the symptom.

The physician gives positive reassurance by informing the patient:

a) "Your health will not suffer if you do not eat. As long as you take vitamins (preferably in natural form) you will stay well physically.

b) "Forcing food will not give you strength. Your exhaustion is a 'nervous ex-

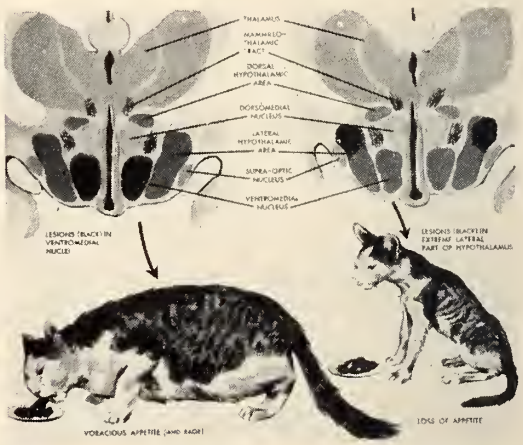


Chart II (from the Ciba collection of medical illustrations by Frank H. Netter, M.D. Copyright Ciba).

haustion,' not a physical one: food will not restore you.

e) "When your depressive mood disappears, you will spontaneously eat and gain weight. When you get over this depression, you will find you need to diet."

Physical Therapy for Depressive States—and for Anorexia

There are three major types of drugs effective in the physical therapy of the depressive state.

1. *Amphetamines:* In simple depressions, an amphetamine combined with a sedative (to alleviate the side effects) is often effective. Thus dextroamphetamine plus amobarbital (Dexamyl spansule) or methamphetamine plus pentobarbital (Desbutal gradumet) given on arising and at lunch will often correct a mild depressive mood —and should be used until the depressive curve returns to normal.

Although the amphetamines are primarily anorexiants, they also have, on occasion, a paradoxical effect; in small doses, the resulting improvement in mood will increase the desire for food and overcome the inhibiting effect of the drug. An excellent formula for this purpose—given as a "tonic"—includes two ounces each of a) elixir Dexedrine, b) elixir Butisol (or phenobarbital), and c) a liquid vitamin (e.g. Trophite); this mixture is given in 2 dram doses one-half hour before each meal.

2. *Monoamine Oxidase (MAO) Inhibitors:* The MAO inhibitors are potent antidepressants. The most common of these include isocarboxide (Marplan), nialamide (Niamid), phenelzine (Nardil) and tranylcypromine (Parnate). Of these in my experience, tranylcypromine (10 mg. tid) remains the most effective; in a small percentage of the patients, the drug is discontinued when marked dizziness or headache suggest the presence of hypotension or the rare paradoxical hypertension. The vast majority of patients respond more quickly to this drug than to the others. Appetite is often improved with the use of MAO inhibitors.

3. *Iminodibenzyls:* This group of drugs, not MAO inhibitors, are also effective antidepressants. Among the most common are imipramine (Tofranil), desimipramine (Norpramin, Pertofrane), amitriptyline (Elavil), and nortriptyline (Aventyl). Imipramine (25 to 50 mg. tid) or desimipramine (25 mg. tid) are effective in many patients who do not respond to other drugs; the primary side effects are dryness of the mouth and excessive perspiration. In some patients, desimipramine is very effective and acts in a relatively short period of time (two to three days); in others, imipramine is more effective but requires one to two weeks to produce therapeutic benefits. There is little change in appetite with these drugs until the depression is alleviated.

4. *Tranquilizers:* In principle, tranquilizers are not effective antidepressant agents; they retard what should be stimulated. Though they have no discernible value in the amelioration of the symptom of anorexia, they do serve to reduce the associated tension and anxiety, and to minimize some of the side effects of the antidepressant drugs.

5. *Electric Shock Therapy:* When these drugs have little or no effect, or when the patient is deeply depressed and suicidal, electric shock therapy remains the safest form of therapy.[6] Electric shock therapy has far fewer side effects (fatalities are very rare, fractures are eliminated by muscle relaxants, amnesia is transitory) and yields results more quickly than do any of the potent antidepressant drugs.

Even when patients are emaciated from a long drawn out depressive illness, they will recover more quickly and have a more rapid restoration of appetite if they are given electric shock therapy without waiting to "build them up." Despite their appearance, these patients tolerate shock therapy well.

Summary

Anorexia is a common symptom of the extremely common, though often unrecognized, endogenous depression. This symptom which is probably the result of inhibition of the lateral hypothalamic nucleus (the "feeding center") is associated with the general hypothalamic inhibition characteristic of the depressive state.

The intensity of anorexia varies with the phases of the illness, as do the weight loss and other symptoms. In the fifth phase, there is increased food intake, despite the continuing absence of appetite.

Therapy of the depressive anorexia is secondary to the therapy of the depressive ill-

ness itself. Therapeutic procedures are outlined and evaluated.

References

1. Anand, B. K., Dua, S., and Shoenberg, K.: Hypothalamic control of food intake in cats and monkeys. *J. Physiol.* 127:143-52, 1955.
2. Brobeck, J. R., Larsson, S. and Reyes, E.: A study of electrical activity of the hypothalamic feeding mechanism. *J. Physiol.* 132:358-64, 1956.
3. Brobeck, J. R., Tepperman, J. and Long, C. N. H.: Experimental hyperphagia in the albino rat. *Yale J. Biol. Med.*, 15:831-53, 1943.
4. Kraines, S. H.: *Mental Depressions and Their Treatment.* New York, Macmillan, 1957.
5. Kraines, S. H.: Manic Depressive Syndrome: a Physiologic Disease. *Diseases of the Nervous System.* (in press).
6. Importance of Shock Therapy in the Treatment of Depressive States, A Symposium. *Dis. of the Nervous System,* 23:1-8, 1962.

MEDICARE WILL AFFECT TEN PER CENT OF BLUE CROSS MEMBERSHIP

Medicare will affect 5.8 million Blue Cross subscribers aged 65 and over, who are enrolled in the hospital-sponsored hospital service plans, a Blue Cross Association study has indicated. What was described as "the final study of full coverage Blue Cross senior subscribers" showed 5,737,343 persons in the 65-plus category as of December 31, 1964. Some increase has occurred during 1965, it was indicated, although figures are not available.

Antone G. Singsen, Blue Cross Association Vice President and Treasurer who made the report, said that future studies of Blue Cross enrollment by age category "will have to differentiate between those at various ages whose coverage is not in part provided by government programs."

Singsen said that "Blue Cross urges all those over 65 to buy the Part B medical-surgical voluntary supplemental benefits made available under Medicare. Those now eligible have only until March 31, 1966 to decide to enroll for those doctor-related benefits." The voluntary social security program costs $3 per month, and the federal government contributes an additional $3. There is no premium for the elderly person to pay for the hospital part of Medicare.

The Association's study of senior citizens enrolled in Blue Cross showed an increase of 420,000 persons 65 and over who had obtained Blue Cross membership since the last report as of March 31, 1963, when 5,317,500 elderly persons had coverage. This was a 7.89 per cent increase in the 21 month period. During the same period Blue Cross enrollment of persons under 65 increased only 3.39 per cent, Singsen said. Both sets of figures included elderly persons participating in several state or local welfare programs which were administered by Blue Cross.

The aged Blue Cross members as of December 31, 1964 represented 10.1 per cent of total Blue Cross members at that date. Aged persons were 9.33 per cent of the total population, as of July 1, 1964 census figures.

Some Thoughts on Longevity

N. Gillmor Long, M.D.
Medical Director
Kemper Insurance

Regardless of one's personal philosophy or religion, most of us are vitally interested in longevity—just being alive. We are sitting ducks for any seheme, within seope of reason, assuring preservation of our present physieal and mental faculties with an eye set on living indefinitely. In this mechanieal age, very few of us are willing to comply with an individualized, ever-demanding rigid sehedule, requiring much constant expenditure of personal effort as well as saerifiee on our part before we ean drink water from the nebulous Fountain of Youth: there is no remote control approaeh. It is mueh easier to sit back and agree with some of the old philosophers who felt that the Fountain of Youth is aetually a state of mind. It is quite possible that even some of the philosophers gave up the ghost when faeed with the Spartan world of reality.

Physieally all men are not born equal and therefore have variable life spans. We all, in addition to possibly being born with struetural and glandular defects, are products of recombinations of aneestral eharaeteristies. Most of us know eertain Winston Churchills; the tough oaks retaining their full physieal and mental stature to a ripe old age in eontrast to those with a shortened genetieal history. Aequired physieal defeets quite definitely enter any equation of longevity, but strict adherence to eommon sense adjustment ean many times prolong life and make every day existence more tolerable. Teddy Roosevelt was born with a frail body but by sheer guts and determination, not only became one of the dynamic leaders of his time, but at an age where most men are eontent with armehair adventure, led the eavalry charge up San Juan Hill as well as conducting numerous big game hunting expeditions. Unfortunately many individuals are physieally unable to undergo this physical metamorphosis. These individuals, with an eye on longevity, have little choice but to follow the striking example of Robert Louis Stevenson, who in spite of chronic tuberculosis was able to adjust his mental life and leave the world as well as himself mueh rieher by giving us his classie "Treasure Island." Perhaps our old philosophers had this type of man in mind when they stated that the Fountain of Youth was in the brain. Very early in life, eongenital or acquired aecidental weaknesses soon beeome apparent and the means of suceessfully overeoming these physical obstaeles never eeases to astonish most physieians. Steinmetz, Helen Keller and Toulouse-Lautrec are but a few of the many examples who eome to my mind at the moment successfully demonstrating the

power of mind over matter. I am certain that every neighborhood can produce similar examples. To obtain longevity, such individuals must constantly strive for physical improvement and, if such is not possible, then quickly learn how to conserve their energy by rolling with the punches of life. In addition to having inherited a reasonably solid framework, the almost equally important adaptation factor of the individual must be carefully weighed. There is very little we can do about our own heritage, there is much we can do about living in what sometimes is a cold, hostile environment, most of it man-created.

Longevity and Specialization

Mass longevity in this era of superspecializations becomes narrowed down to a relatively small group of individuals charged with the responsibility for international Public Health problems of protection of food and water preservation, sewage and waste disposal and control of contagious diseases. With cities the size of London, Bombay, Moscow, New York, Chicago and Los Angeles, such public health protection becomes increasingly vulnerable to chance or planned bacterial or radiological contamination. The law of the jungle continues to be intertwined in the pattern and fabric of modern civilization faced with the potential of mass extinction, as remote as we would like to believe it is in our consideration of longevity for the individual. At any moment the spear of heaven-fire feared by the savage can affect the longevity table of our civilized man with his hydrogen bomb and chemical biological agents. Dr. Broune pointed out: "After all, civilized people at bottom are perilously close to the savage." Longevity is definitely influenced in our 20th Century living by the breathtaking progress unequaled in the history of mankind. The New England Journal of Medicine summed it up neatly when it stated: "As the low vaulted past gives way to the praetically vaultless future, medicine turns its attention to maintaining human life under conditions of incredible velocity, extremes of temperature and an exterior environment that contributes nothing to the pioneer spaee traveler but unavailable elbow room."

For the earthbound 20th Century American and Canadian eitizen, the Annals of the American Academy of Political and Social Science points out the "extraordinary record of low mortality and high longevity. The average length of life in these two countries, which had a population of 190 million at the beginning of 1958, is about seventy years—this situation is, for the most part, a development of the present century." More favorable environmental influences, expanding public health program control of infectious diseases, earlier recognition of cancer and heart and kidney diseases—all these vital factors play an important role in the individual problem of longevity.

Having very neatly tied up with pink ribbons a few of the elements having a definite bearing on the individual's life span eompletely out of his control, where do we go from here? For the reader, it is necessary to bring the image of personal adaptability into closer focus; to spot the several variables that blend into any discussion centered on your longevity plan per se. One writer phrased it "reshaping the human figure."

The Philosophy of Hunger

The philosophy based on hunger and frustration differs sharply from that stemming from the well fed student. So we will have to assume for all practical purposes that the reader represents, as far as he is aware, a normal everyday reasonably eontented individual enjoying food and good health. His problem is continual maintenance of his present happy life; not quite knowing what the hereafter may be like, he is quite anxious to extend and prolong his individuality into the future.

There are many sandtraps and water hazards that influenee his physical well being—knowing those handicaps makes it easier to ehart his future course in the fairways of the future. There are many danger signs, fortunately, most of which are apparent to the individual not counting automotive accidents, ignoring of common sense, home and work safety rules, the countless man-made hurdles of our present

high-speed living in this age of mechanization with greater production and less physical effort.

Overweight and Longevity

One of the most apparent of sandtraps, easy to drive into and fortunately equally easy to blast out of, centers on food intake. Much paper pulp has been utilized on this business of dieting and caloric intake for it is aeknowledged that overweight has a direct bearing on longevity and physical well being. We will not go into all the pros and cons of obesity for there is no question as to the seriousness of this disease —now quite rightfully (exeept for persons afflieted by glandular imbalance) being eonsidered every bit as degrading as chronic alcoholism. In my opinion this is the first eonquest, the first obstaele that must be overcome before lengthening the life span or perhaps more important, enjoying life as it is experienced today. One cannot exercise with any safe margin of protection until he or she is down to within twenty pounds of the accepted weight average for his or her age and build. Most of us consume food volume well over a daily adult male intake of 1500 calories, designed for persons engaged in heavy physical labor. All of us will at times overeat on a special oeeasion, but learn how easy it is to spread those extra ealories over one to two days' time, once this control habit is working. It is the continual overeating, just as over-indulging in anything else, that directly upsets our blood makeup, medically termed, serum lipoprotein, cholesterol and carbohydrate ratios and overeating is bio-statistically proven to accelerate atherosclerotic ehanges. We now speak of coronary atherosclerotic heart disease, the replacing of an efficient pliable, smooth normal vessel lining with a hardened mixture of fat and roughened, unyielding tissue that narrows the blood system and heart valves, decreasing cardiac and circulatory output. Dr. Osler, the great Canadian physician, stated that individuals should strive to live in a happy state of equanimity. Dr. Schindler pointed out in his book "How to Live 365 Days a Year" that blind rages, fatigue, extreme ranges of emotions all affect bodily functions and are solved by overweight people, not through a correct philosophical adjustment or religious release, but by overeating, a merry-go-round technique. Cocktail parties and the ceremony of elaborate dining have become an institution in all business and social worlds so that it takes a clever, strong willed person to neatly and courageously tight-rope walk over the dangers of the *ever present* sandtrap of obesity. To those interested in longevity; food has to immediately call forth automatic subconseious flashes of control signals. If the sight of food, whether or not it be that extra chocolate bar, a second Manhattan, or those tempting Lyonnaise potatoes, makes you see a heap of extra ealories, visualize the potbelly you are working so hard to reduce and then, and only then, can you take the first step toward living with yourself and projecting into the future. If you suceumb, and who doesn't, the mere fact that you have built up a guilt complex will help in round two.

Exercise Is Important, Too

After conquering, or at least becoming caloric minded to a practieal degree, obesity and food intake, what then? It now is safe to exereise within moderation, based on age, physical stamina and sport availability and schedule. There is little question, the factors earlier mentioned considered, that daily exercise adds to longevity. A reeent conferenee at the New York Medical College, the findings of the Jaffa Hospital Research Center in Israel and statistics from the Metropolitan Life Insurance Company all support this belief. Medical journals are full of articles pointing out the fact that heart disease is less frequent with those who exercise routinely each day.

This doesn't include the professional athlete, who oceasionally can be overtrained. An issue of the New York Times had the now familiar pieture of King Gustaf V of Sweden, at ninety-two years of age, playing tennis when in his eighties, with the caption "Did tennis in his eighties help him reach that age?" We truly don't know, but I do know that I feel better, walk easier and breathe better when I have lost weight and exercise a little eaeh day. I also know I puffed tying my shoestrings before I lost weight; a danger signal not to be ignored if I wish to keep my blood pressure normal.

Sustained high blood pressure throws added strain on the heart. Automobiles, pushbutton living, TV postural inactivity now call for systematic dieting, plus moderate systematic exercise. Upon attaining the fifth and sixth decade of life, one has to safeguard carefully against the sandtrap of too soft and easy a life. Daily exercise, rigid weight control, carefully balanced nutritional diet, limited cigarette and alcoholic intake is not a transient fad, but a must, a daily must if one is at all interested in efficient work output and long years ahead. Avoidance of more than one piece of bread or two pieces of toast a meal, avoidance of all dessert except fruit, cutting the intake volume in half will start you on your way and make medieal guidance easier. If you are strong-willed, a rugged individualist; this dietary control cannot be done easily, but *it can be done* by self control. In the long run, this is superior to relying on passive help from drugs or substitute products. Once you have started to brag to your friends about your new look, the easier it is to continue on the right track. It is the getting started that is diffieult in this problem so vital to longevity.

The Controllable Factor

To reiterate: Having lost weight and well adjusted as to food intake, the other controllable factor in this business of longevity is that of exercise. This is no problem up to 40-45 years of age, assuming that the conversion from a continual "sitter downer" is not too rapid the first month or so. A few figures might be of interest, relative to the heart and exereise. The estimated output of the normal heart volume is 60 to 70 cc per beat (1000 cc to a quart) with the normal amount ejected into the blood stream per minute, ranging from three to five liters or approximate quarts. Now, during strenuous exercise, the stroke volume increases to 100-200 cc per stroke, with an associated increase in heart rate, the cardiac output per minute during strenuous exercise may be increased to nine times that of normal. There is, as with air in the lungs, a certain residual amount of blood in the heart. With this increase in circulating blood volume comes an added amount of oxygen to the tissues and carrying away of waste products. With the increased metabolism of this reflex action comes a tuning up, as it were, of all body tissues including brain and nervous system. One cannot help but get a feeling of increased well being not shared by watching, for hours at a time, your favorite TV baseball show. There is little need to go further into this matter of increased efficiency with a lowering of body sludges which can be pictured as clogging up a reasonably designed effieient human body. What is more important is the finding that atherosclerosis can be a reversed reaction with many biophysiologists and bioehemists stating that, with proper diet and daily setting up exercises, the blood vessel tone can be restored to its nearly normal resiliency. This is important for it is another word for longevity.

Walking, the Almost Perfect Exercise

In England, the Oxford University graduates, formerly active in school athletics, band together and, as they find themselves getting more and more immersed in a sedentary life, regulate their exercises accordingly, gradually tapering off and carefully observing the cardinal rule of moderation at all times. Unless one plays tennis, handball and even golf once or twice weekly, with daily setting-up exercises, then after age 40 to 45 it is my firm belief that walking is the only safe exercise. Walking has this distinct advantage. It can be done anywhere, anytime and in all sorts of weather and requires no special equipment. One can measure one's fatigue yardstick easily since age is not a factor. A brisk walk, breathing deeply for a few minutes every 10-15 minutes while walking over uneven ground, is considered the most productive from a return value standpoint. Walking combined with abdominal strengthening morning exercises will reduce any waistline as abdominal muscles will return to normal tone if given a daily workup, slowly accelerating the length of time and tempo each day. Daily swimming is superior for the lucky few having available pools, Florida weather or inside club pools. There is no distinct advantage in being machine propelled around a golf course, from an exercise standpoint, if it has reached the point of not being able to walk nine or eighteen holes of golf, then

one should stick to shorter, straight walking distanees.

It should not be neeessary to remind all persons engaged in athletics requiring any severe unusual output of energy to avoid drinking anything during the game or exereise. An equally important thing to remember is to take your own pulse every half hour during that exercise time. Rapid inerease in rate or a thready pulse calls for immediate rest until normaley is reached. This little idea has saved many a coronary attaek in the unfortunately too frequent ease of the man who forgets he is no longer the Jesse Owens or the Frank Merriwell of his past. There is nothing more potentially dangerous than the Elk or Rotary Pienie, with the "old" man athlete for the day to forget that time has marehed on. Cardinal Newman, in "The Second Spring" expresses it so well: "We look at the bloom of youth with interest, yet with pity; and the more graceful and sweet it is, with pity so mueh the more; for whatever be its exeellenee and its glory, soon it begins to be deformed and dishonored by the very foree of its living on." A smug thought for we golf duffers who can't get lower than 110 or we guys who made the seeond team, but never good enough for the first. Seriously, we all want to prolong, through proper dieting and sensible exercising, the delay of the "deformed" stage to increase longevity.

Two Aspects of the Problem

One eould write volumes on the subject of longevity and approaeh it from many angles. I have purposely foeused on only two fundamental aspeets of the problem; to enlarge on either of these two main approaehes would be repetitious. Certainly neither is new or startling, but neither are the Ten Commandments or The Lord's Prayer, yet nearly all Christian dogmas and ereeds are based on these simple, but effective words. Just as we should daily repeat these ereeds as well as wedding vows, we should daily eheek our Longevity Profile for dietary control and some form of exereise, on these two postulates hang all the laws of gracious living and possible inereased life span.

Many years ago, one of the Mayo Clinic Bulletins printed an artiele on longevity: "Man spends approximately the first twenty-five years of his life in the preparation of maturity, to learn a trade, an occupation or a profession. When this preparation is aehieved sueeessfully, the daily round demands inereasing applieation, aetivity and responsibility and the stress and strain contingent on the eonstruetive execution of the daily program are increased. Man grants little eonsideration to an equally important period of preparation, that for the post-prime years of life, when modifications in his mode of working and living are exaeted by the inevitable biologie laws. Only too often man believes himself immune to nature's seheme (a few appear to be) and relentlessly carries on with ever increasing industry until some vital strueture fails and sudden dissolution or pathetie invalidism results."

A Fatalistic Attitude

Some individuals, during their robust years of life, assume a fatalistic attitude and boastfully proclaim their willingness to chance such eventualities at a premature age, little realizing the probable change in their philosophy, when amendments are no longer possible.

Human beings are individuals and therefore the program of life must be individualized in order to assure its adequaey. The ambitious individual is frequently intense in his activities, both in work and reereaiton and it is to him partieularly that admonitions must be direeted. It is well for this large portion of the human race to contemplate life with a philosophie view. When the eurve of deelivity begins, whieh obviously varies with different individuals, but occurs fairly uniformly in a span of five to eight years, loads of all sorts must be lessened. This means shorter hours of application, greater deliberation in the execution of duties, a slower eadence of activity, more frequent periods of rest and relaxation and systematieally inereased intervals of recreation. Reereation also should be less strenuous to avoid any sudden and unaeeustomed stress on the heart. Only too frequently sudden death eventuates when the middle-aged or elderly man disregards discretion and through the memories of a more robust era attempts ridieulous feats of physieal prowess.

Let the skeptics disbelieve, but before so doing, let them look around and make appraisal of the venerable persons among their acquaintances who are still contributing to and enjoying life.

Henry Wadsworth Longfellow wrote to a friend on his seventieth birthday: "You do not know yet," he wrote, "what it is to be 70 years old. I will tell you so that you may not be taken by surprise when your turn comes. It is like climbing the Alps. You reach a snow-crowned summit and see behind you the deep valley stretching miles and miles away and before you other summits higher and whiter which you may have strength to climb or may not. Then you sit down and meditate and wonder which it will be. That is the whole story, amplify it as you may. All that one can say is, that life is opportunity."

WHAT OUR SOCIETY DOES FOR US

After reading the artiele, "Services to the Profession," which appeared in the February 21 issue of the American Medieal Association News, on the increase in dues recommended by the Board of Trustees of the American Medical Association, I felt that I should express my feeling in this regard.

Little do we realize how much our county and state medical societies and the American Medical Association do for the doctors and also how much they are able and willing to do for us only for the asking.

The following are some of the benefits of the American Medical Assoeiation plus the benefits of the Illinois Medical Soeiety and the Chieago Medical Society:

1. The latest developments in medical science presented at the Annual and Clinical Conventions.
2. The services of the Washington Office which include continuing liaison with members of Congress and government agencies on a wide variety of matters affeeting medicine as well as the handling of requests from physicians and medical societies for information and assistance.
3. A library of medical films, the largest in the world, each film available on request.
4. A variety of practice management aids to assist the physician in operating his office efficiently and economically.
5. Numerous authoritative health education pamphlets and other materials for distribution to patients.
6. Expert advice on medicolegal problems.
7. A comprehensive library service.
8. A physician placement service to help the physician who wants to relocate to find the community best suited to his desires.
9. A huge storehouse of information on a variety of scientifie subjeets, including drugs and drug therapy, foods and nutrition, pesticides and poisons, and numerous others.
10. Hundreds of meetings annually for constructive evaluation and decision on important medical and soeio-economic developments.

I am proud to be a member of the Chicago Medical Society, the Illinois State Medieal Soeiety, and the American Medical Association, and I am happy and willing to pay an increase in dues. The more we support our societies the more they can help and protect us. Theodore Roosevelt once said "I hold that every man owes something of his time and substance to the upbuilding of the profession or industry from which he gains his livelihood."

August F. Daro, M.D.

AN ANALYSIS OF THE OPINIONS TOWARD MENTAL HEALTH AMONG NURSES AND PHYSICIANS IN DEKALB COUNTY, ILLINOIS

Irving Frank, M.D. and
Marvin Powell, Ph.D./sycamore

If we are to consider the opinions of people as molding their behavior toward others, it beeomes necessary to understand the formation and integration of information. Nunnally defines opinions as being synonymous with knowledge. The opinions that we accumulate with experience seem to alter or enhance our responses to particular events or objects.

This study represents an attempt to investigate the presence of differences of opinions between two professional groups. One is the medical profession and the other a paramedical group (nursing). It is the authors' intention to determine if there is a significant difference between these two groups and to indicate briefly approaches that may be used to alter opinions in these groups.

"The greatest public health problem at the present time is mental illness. It fills more hospital beds than cancer, heart disease, and tuberculosis combined; and for every totally disabled inmate of a mental hospital at least two others are living in the world, not sick enough to be institutionalized, not well enough to live healthy happy lives."[1] Studies have indicated that opinions are less negative among the younger and better educated persons than the older and less educated groups. We become embarrassed at times when we recognize that many members of learned professions are apt to have negative opinions toward the major mental problems.

From the past we have inherited an unpleasant and even frightening image of the mental patient. While the pieture is rapidly changing, even today mental illness is too frequently regarded as a weakness of personality to be deplored, or a welfare problem to be cared for as cheaply as possible. Undoubtedly, the public opinion toward mental illness has been deeply affected by the spectre of the huge custodial "government asylum," so different from the larger hospital in our communities. The medieal profession has a central role to play in identifying an emotional or mental problem, referring it to the community mental health serviee and later participating in treatment during the rehabilitation phase.

Medical schools eontinue to perform the classic function of creating the environment in which students of diversified interests, talents, and goals may acquire the habits of study, basic skills, and a sense of personal responsibility for patients that motivates the true physician. The vital ingredient in such an approach is to produce a competent physician or scientist with orientation to psychological problems as well as the classical "organistie approach." Basically, there are three objectives of education at any level. The first is the acquisition of information without which little else is possible. This implies that information is at the heart of learning, but information alone is rarely enough. An equally important outcome is usually some understanding of the information, a feeling for it, a comprehension of it, or an ability to translate it into some new form. Finally and perhaps most important of all, is the acquisition of opinions which will ultimately influence the nature of the physician's relationship to patients, to colleagues and to learning itself.

The sample of subjects were physicians and active nurses of the DeKalb County area. The total number of subjects was 69 of which 23 were physicians and 46 nurses.

TABLE 1

Total Group (Physician-Nurses)

Class	*N*	*Mean*	*S.D.*	*Mean Diff.*	*S.E. of Diff.*	*T Score*
M.D.	23	214.65	29.360	9.44	6.8831	1.3714
R.N.	46	224.09	25.69			

Physicians With Resident Training—
Physicians Without Resident Training

Class	*N*	*Mean*	*S.D.*	*Mean Diff.*	*S.E. of Diff.*	*T Score*
M.D.	13	219.54	25.993	11.24	12.40	.9061
M.D.	10	208.30	33.5890			

The physicians represented approximately 50% of the total population of physicians in the DeKalb area, and the nurses represented approximately 40% of the active nurses in the DeKalb area. The age groups represented were 21 persons in the 20-30 year level, 29 persons in the 30-50 year level, and 19 persons in the 50 year and over level. All of the physicians were males, and all of the nurses were females.

The instrument used was the "Information Questionnaire" developed by Osgood and Nunnally at the University of Illinois. These investigators formulated this final 60 item questionnaire out of an original 3,000 item questionnaire. They attempted to study public reaction to mental illness to uncover just what were the popular conceptions of mental health. These researchers relied heavily on the questionnaire-type measuring instrument. In using instruments of this kind, the validity of responses is always questionable. They attempted to use experimental control design rather than before-after design for most of their studies. The questionnaires were used with the general public, experts, and general physicians.

About 150 information questionnaires were distributed to all of the physicians and nurses in one complete count in Illinois, and 69 were returned. The scores of the 23 physicians ranged from 171 to 270; the range for the 46 nurses was from 171 to 298. Analysis of the data using a "t" test failed to reveal any significant difference between these two groups on the information questionnaire. (See Tables 1 and 2.) In comparing the physician who had resident training with those who did not have resident training, analysis of the data also failed to reveal any significant difference between these two groups. The third analysis compared physicians whose families experienced mental illness with physicians whose families did not experience mental illness. The fourth analysis compared physicians whose families experieneed mental illness with nurses whose families also experienced mental illness. The fifth analysis compared physicians whose families experienced mental illness with nurses whose families did not experience mental illness. The sixth analysis compared physicians whose families did not experienee mental illness with nurses whose families did experience mental illness. The seventh analysis compared physicians whose families did not experience mental illness with nurses whose families did not experience mental illness. The eighth analysis compared nurses whose families did not experience mental illness with nurses whose families did experience mental illness. None of these analyses revealed significant differences.

Summary

Sixty-nine individuals of the DeKalb area responded to the information questionnaires, of which 23 were physicians, and 46 were nurses practicing in the DeKalb County. There was no significant difference between these two groups in terms of information concerning mental health as observed by their responses to the 60-item information questionnaire. Also no significant difference was found between physicians with resident training and those without resident training. Perhaps most significant was the finding that there was no difference between those individuals who have had mental illness in their families and those who have not had mental illness in their families.

In conclusion the authors feel that an educational program that does not provide substantial experience in community and public hospital psychiatry cannot be considered adequate. By integrating university and state mental hospital programs, an educational experience could be developed that might prove meaningful to the individual physician in assuming greater responsibility for the detection, diagnosis, and treatment of patients who live in their community. Perhaps, too, some greater emphasis on interaction with psychiatric patients could be included in the internship training and in residence training regardless of the physician's specialization.

References

1. DeRapp, R. S. *Drugs and the Mind.* St. Martin's Press, New York.
2. Eisenberg, Leon. *Preventive Psychiatry If Not Now—When.* C.M.H. Supplement #36, April 1963.

TABLE 2

	N	*M*	*S.D.*	Ex^2	*MD*		*SE*	*t*
M.D. with Mental Illness	5	218.40	29.177	3405.20				
					4.79	29.99	15.16	.3159
M.D. without Mental Illness	18	213.61	30.176	15480.28				
M.D. with Mental Illness	5	218.40	29.177	3405.20				
					.40	22.86	12.52	.0319
R.N. with Mental Illness	10	218.00	19.397	3386.00				
M.D. with Mental Illness	5	218.40	29.1770	3405.20				
					8.540	26.93	12.9019	.6619
R.N. without Mental Illness	34	226.94	26.65	23441.88				
M.D. without Mental Illness	18	213.61	30.1760	15480.28				
					4.39	26.9374	10.6242	.4132
R.N. with Mental Illness	10	218.00	19.3970	3386.00				
M.D. without Mental Illness	18	213.61	30.176	15480.28				
					13.33	27.90	8.1327	1.6390
R.N. without Mental Illness	34	226.94	26.6530	23441.88				
R.N. with Mental Illness	10	48.00	19.3970	3386.00				
					8.94	25.2736	9.0919	.9832
R.N. without Mental Illness	34	226.94	26.6530	23441.88				

MELANOMA MASQUERADING AS A PSYCHOSOMATIC DISORDER

John C. Kulis, M.D./chicago

Malignant melanoma is one of the less common forms of cancer. It may be pigmented or non-pigmented in its primary and secondary manifestations.

The purpose of this paper is to present a case of metastatic melanoma which clinically simulated a psychosomatic disorder and to describe the vagaries of this disease which made the actual diagnosis obscure.

Report of a Case

A 59 year old white male was admitted to Swedish Covenant Hospital on February 20, 1962 with complaints of bilateral anterior and posterior chest pains radiating to back. He also had had anorexia and weight loss of several months duration. The patient presented a history of ill health of several years which consisted of constant chest wall and back pains.

In July 1959 the patient had a complete study at a University Center for the above complaints and was discharged with the diagnosis of generalized idiopathic osteoporosis and anxiety neurosis. Following this, the patient was seen by several psychiatrists and medical practitioners who treated him with analgesics and tranquilizers.

Physical examination revealed a chronically ill male with an oral temperature of 100.2° F. Sinus tachycardia, 110 beats per minute; respiratory rate, 18 per minute; and blood pressure 120/80 Hg; no adenopathy was noted. The sclerae revealed no icterus. Chest examination revealed occasional dry rales in left lower lobe. Examination of the heart revealed a systolic, precordial murmur, Grade 2. Abdominal examination revealed a liver palpable 4-6 cms below the RCM, non-tender and firm; the spleen was not palpable; the extremities showed no edema. Sternal tenderness and tenderness over several of the lower right and left ribs was elicited on palpation.

The hemogram revealed a hemoglobin level of 12 gm %, hematocrit of 35% mm, and a white blood cell count of 12,500/-cm/mm, with 62% neutrophils, 18% lymphocytes, 1% myelocytes, 3% metamyelocytes and 16% bands.

Blood chemistries revealed the following: Uric acid 8.8 mg %, alkaline phosphatase 45 Bodansky units, Total Bilirubin 0.55 mg %, and a urine test for Bence Jones protein was negative. The EKG was within normal limits. An x-ray of lumbar spine revealed no abnormalities. The chest x-ray revealed a mass in the left middle lung (superior segment of the left lower lobe). Destruction of the postero-lateral aspect of the right 7th rib was seen on x-ray; also, compression fractures at the level of D-8-11 dorsal spine. A bone marrow study revealed complete replacement by abnormal foreign cells.

At autopsy, gross findings revealed multiple softened areas throughout the skull vault. The cerebral cortex showed small blackish softened areas scattered throughout the cortex. In the lower lobe of the left lung circumscribed firm, tan tumor nodules about 3 cms in diameter were seen. The liver revealed multiple grayish tumor nodules up to 2 cms in diameter. The mes-

enterie and retroperitonal nodes were slightly enlarged and grayish tan in eolor. The mesentery revealed multiple dark reddish, purple, slightly elevated areas. Many ribs were diffusely infiltrated by tumor tissue and revealed multiple fraetures. The thoraeic spine at the levels of D 8 and D 11 was diffusely infiltrated by tumor tissue and these vertebrae showed compression fraetures.

Mieroseopic study revealed metastatie melanoma of lungs, liver, adrenals, mesentery, spleen, bones, and brain.

Comment

This case depieted some of the usual features seen with melanoma and re-emphasizes some known faets of the life history of this disease. Melanoma may arise from almost any organ in the body; however, the most common is the skin followed with the eye, anus, adrenals in this order of frequeney.[1] In many eases the disease will follow the pattern of most loealized neoplasms spreading to the nearest lymph-node area. In some, there is spread through the lymphaties or vaseular ehannels to distant organs; this spread is to the liver, lungs or brain direetly.

In this ease, after an apparently suecessful treatment of the primary melanoma by loeal total excision, delayed metastases oeeurred six years later. It is believed that dissemination occurs before the primary tumor is removed.[2] The tumor emboli remain quieseent where they lodge, though still in a viable state. After a long period of time, they are stimulated to grow by some unknown faetor, and they manifest their presenee. Cases have been reported where metastases did not appear for as long as 15 years after removal of the primary tumor. The longest period on reeord is 32 years.[3]

The belated appearanee of metastases in such organs as the liver or brain, many years after the original diseovery of a melanoma, may result in a new and erroneous diagnosis.

The many physieians who had seen the patient in the past six years were not informed that a mole had been removed from his right arm six years previously, and the patient did not relate this information. In this patient, extensive metastases to bone resulted in vague pains and weakness. The pains were interpreted as part of an anxiety reaetion by several psychiatrists. The diagnosis of osteoporosis was made on the basis of roentgenographie changes. Metastatic malignaney may present an identieal pieture.[4]

The diagnosis of funetional disease is usually arrived at by exelusion. Though this process is recognized as unreliable, we usc this method beeausc there is no universally aceepted teehnique whieh may differentiate between organie and funetional disease.

If organie pathology has not been found, most physieians deeide that the symptoms must be on a functional basis. Infeetion, degenerative disease, or malignaney, however, may occur in a troubled, anxious patient. The diagnosis of neuroses should be made on positive findings having origin in the personality. It is neeessary to obtain evidenee of emotional instability in addition to a personality deseription that gives proof of eontemporary or past eonfliets in the person's life.

A leukoerythroblastie anemia was one of the elinieal clues to a malignaney involving bone that prompted a bone marrow aspiration whieh revealed a marrow replaced with foreign eells.

Beeause of the laek of melanin in the cells, the diagnosis eonsidered was either a reticulum eell sareoma, anaplastic myeloma, or metastatie eareinoma; only after his death was the eorrect diagnosis established.

Summary

The elinieal pieture and neeropsy data of a case of melanoma masquerading as a neuroses was deseribed.

The long latent period of delayed metastases and the difficulties encountered in the diagnosis were discussed.

Caution in diagnosing neuroses by the proeess of exelusion of organic disease was emphasized.

References

1. Ackerman, L. V., *Am. J. Clin. Path.* 18:602, 1948.
2. Adelson, Lester, *Conn. State M. J.* 15:1951, p. 6-13.
3. Willis, R. A.: *The Spread of Tumours in the Human Body,* London, J. and A. Churchill, 1934.
4. Cecil, *Textbook of Medicine,* 9th Edition, p. 1447, 1955.

David Prince, Pioneer Surgeon

Frank B. Norbury, M.D./jacksonville

1966 MARKS THE ONE HUNDRED-FIFTIETH anniversary of the birth of David Prince, one of the first teachers of Anatomy and Surgery in Illinois, pioneer in Orthopedic and Plastic Surgery, and organizer of many medical societies. While most accounts of pioneer medicine stress the family doctor with his saddle bags and his quinine and calomel, it should be recalled that there were others in the early days who were true students of medicine, familiar with the work being done in Europe and the Eastern United States, reading and reporting on the literature in several languages, and performing sophisticated surgical operations.

Such a man was David Prince who was born on June 21, 1816 at Brooklyn, Windham County, Connecticut. His father, also named David Prince, was a farmer and later a miller and the Prince family records in New England go back as far as 1662. His mother, also a New Englander, was Sophia Ellsworth. The Prince family took part in the Western migration from Connecticut to upstate New York. They settled on a farm near Canandaigua, New York, and young David was educated at the Canandaigua Academy. Later the family moved on west to Payson, Adams County, Illinois, where the father operated the first store and mill. David stayed behind, however, for he had decided to study medicine.

David Prince first attended the College of Physicians and Surgeons of the Western District of New York. During the thirty years of its existence, this school, located in the tiny village of Fairfield, Herkimer County near Little Falls, numbered among its graduates many illustrious names in American Medicine including Nathan Smith Davis, founder of the American Medical Association, and Daniel Brainard, founder of Rush Medical College. By the time Prince went there, however, it was already beginning to feel the competition from other better-located schools in the larger cities of Geneva and Albany, and the education offered at Fairfield must have been woefully inadequate. The classes started in November and lasted for only three months so that students could be at home in the spring and summer to help out with farming.[1]

In 1836 and 1837, while Prince was at Fairfield, Reuben D. Mussey was professor of surgery. Mussey, one of the great surgical teachers of the 19th century, probably had more influence on David Prince than any other man. He had been born in 1780 and was first a pupil of Nathan Smith, the founder of Dartmouth Medical College. Later in 1806-07 he studied at the University of Pennsylvania. The leading light of Pennsylvania medicine at the time was Benjamin Rush, great physician, pioneer psychiatrist, and signer of the Declaration of Independence. Rush

has been deservedly called the first great physician in America, but he was a dogmatic systematizer, unwilling to experiment or to change his theories to fit the facts.

Mussey had a more original mind and did not hesitate to carry out experiments, even on himself. It is recorded that "as a mere fledgling in medicine, Mussey attracted considerable attention by taking issue with Benjamin Rush who thought that the skin was non-absorptive. Mussey experimented in various ways to prove that the skin does absorb. He immersed himself in a bath containing three pounds of madder with sufficient water to cover the entire body. For days following, the urine showed the presence of madder. He also proved that rhubarb can be absorbed through the skin. He went so far as to immerse his body in a strong solution of nutgall, and subsequently in sulphide of iron to find out whether he could not pass ink instead of urine. This experiment nearly proved disastrous. Mussey took very sick and decided not to repeat his attempt to make an inkwell out of his body."[2]

No Future in Fairfield

By 1837, it was apparent to Mussey that the Fairfield school had no future and he accepted the Chair of Surgery at the Medical College of Ohio in Cincinnati. He must have influenced Prince to go with him, for in 1838 Prince also left Fairfield and entered the Medical College of Ohio. The history of medical schools in Cincinnati revolves around Daniel Drake (1785-1852) who was the great pioneer physician of the Middle West and whose descriptions of Cincinnati and of the diseases of the Mississippi Valley are classics of literature as well as medicine. Although Drake was a founder of the Medical College of Ohio, he was forced out of its operation only to re-enter several times after trying to establish other medical colleges in competition with it.

Prince graduated from the Medical College of Ohio in 1839. He stayed in Cincinnati after graduation as a private pupil and assistant to Mussey. In 1841, he followed his family to Payson, Illinois, and established a general practice there. He was attracted by the prospect of a medical school at nearby Jacksonville.

The Trustees of Illinois College in Jacksonville, little more than ten years after the founding of the College, resolved in 1841 to start a medical school. In June, 1843, the trustees authorized the establishment of the school, the election of professors, and the leasing of "such public rooms in the Chapel (Beecher Hall)—including the north attic—as the Academical Faculty shall think can be separated from the purposes of the Academical Department."[3] The first professors were: Anatomy and Surgery, David Prince; Chemistry and Materia Medica, Samuel Adams; Obstetrics and Diseases of Women and Children, Henry Jones; and Theory and Practice of Medicine, Daniel Stahl.

Classes on a Farm Schedule

Illinois College, like the Fairfield school, was located in a farming area and classes started in November and ran through April. Instruction began on November 1, 1843, and there were fourteen in the first class, six of whom graduated that year with the M.D. degree. Beecher Hall was totally inadequate in size and facilities for medical instruction; therefore, in the summer of 1844, a frame building at the southwest corner of Lincoln and Mound Avenues was fitted up for medical classes. This was a two-story building with a large dissecting room on the second floor. The Illinois College Medical School existed only from 1843 until 1848. It always seemed to have plenty of students, but the fees were paid directly by the students to the professors rather than through the college administration, and it is known that Prince and others often gave their courses on credit, hoping to be paid when the crops were in or even later when the students were in practice.

Jacksonville in the 1840's was the largest town in the State, but already Chicago was beginning to grow, and medical students soon saw the advantages of schools in larger cities. Two medical schools were founded in St. Louis in the 1840's and Rush Medical College in Chicago was founded a few months after Illinois College Medical School. It was inevitable that just as David Prince's first alma mater in Fairfield, New York, could not survive this competition, Jacksonville was not destined to continue as a center of medical education.

The Anatomy Question plagued medical education in the 19th century. As Prince was to point out later, physicians were likely to be sued for malpractice if they did not know the anatomy of the human body, and likely to be arrested as common criminals if they attempted to obtain bodies for dissection. All medical schools resorted to "Resurrectionists" — grave-robbers — a necessary source to obtain bodies until adequate Anatomy Laws were enacted. The story of these grave-robbing activities forms an interesting if somewhat shady chapter in the history of medical education, and has been immortalized in Mark Twain's "Tom Sawyer." Prince must have used bodies obtained from graves for his anatomical studies and teaching—all anatomists had to. Most of them were reticent in their memoirs about these episodes and indeed they must have done this work at great peril to life, limb and reputation. At St. Charles, Illinois, a physician was killed by an angry mob after a "resurrection" in the 1840's.[4] As late as 1878, the public in Cincinnati was aroused (and later passed adequate Anatomy Laws) when the body of John Scott Harrison, son of President William Henry Harrison and father of President Benjamin Harrison, was discovered in the anatomy theatre of Prince's old school, the Medical College of Ohio.[5]

For years it has been rumored that Illinois College was forced to close its medical school because the body of Governor Joseph Duncan was dissected there. Duncan, third Governor of Illinois, died in Jacksonville on January 15, 1844.[6] Illinois College Medical School had only been in existence two and one-half months and was still holding classes in Beecher Hall which had no real dissecting room. Although Duncan's body might have been dissected in a barn or elsewhere, the Medical School continued for more than four years after his death. Therefore, the dissection of Duncan, if it ever occurred at all, was certainly not responsible for the closing of the school.

Prince apparently commuted from Payson to Jacksonville from 1843-45, but by 1845 he had established an office in Jacksonville.[7] It was in that year that economic success must have come to him, for he was married to Mary Jane Dawson. In the winter of 1845-46, Edward Mead, a fellow Professor at Illinois College, along with Judge William Thomas and Dorothea Lynde Dix influenced the legislature to establish Illinois' first mental hospital at Jacksonville. Prince was on the committee which selected the site at the south edge of the city where the hospital is still located.[8] Also in 1846, Prince was associated with the first short-lived Morgan County Medical Society, and in 1847 was a founder and first secretary of the original Illinois State Medical Society which was formed in Springfield on December 16, 1847, and existed for a short period.[9]

In 1848, when Illinois College Medical School closed, Prince left for St. Louis where he became Professor of Surgery at the St. Louis Medical College (Pope's College). Little is known about his life there. His wife died in 1850, probably in St. Louis, and three children had preceded her in death so that this five-year marriage must have been one of constant tragedy.

Love Comes With Lucy

Prince then met Lucy Manning Chandler who had come to Illinois to visit her uncle and to attend school at Monticello Seminary in Alton. Her uncle was Dr. Charles Chandler, a physician and close friend of Abraham Lincoln. He had invested in real estate and established the town of Chandlerville (now Cass County), Illinois. On May 10, 1852, Prince and Lucy Chandler were married in Fredonia, New York, and established residence in Jacksonville. Perhaps through the influence of his wife's uncle, David Prince became an early supporter of Lincoln against Douglas. In 1853, he was one of the organizers of the Free Democratic Party in Jacksonville—a forerunner of the coalition of Free-Soilers, Whigs, and Free-State Democrats who later formed the Republican Party.[10] Prince's family tell of his using his house as a station on the underground railroad and that he drove the escaped slaves to the next station at Dr. Chandler's house in Chandlerville while supposedly making night calls.

He continued to be active in medical organizations and was a delegate to the seventh AMA Convention in St. Louis in May, 1854. One month before that, his

eldest son, Arthur E. Prince, was born. At the Decatur Convention of the Illinois State Medical Society in 1859, he was elected President of the Society at the age of 43. He gave his presidential address in 1860, discussing medico-legal matters, including the dilemma of the physician who could be sued for not knowing anatomy and arrested for attempting to learn it. At about that time, the family moved to the Jacksonville home which they occupied until his death, on West State Street at the corner of Fayette. This location, now the site of an automobile agency, is marked by a stone commemorating Prince's residence and early office there.

First of the Brigade Surgeons

In 1861, General McClellan's huge army was training in and around Washington. Charles S. Tripler, the Medical Director of the Army of the Potomac, was endeavoring to form in the Army a group of medical officers who were experienced in the profession and who would have national rather than state loyalty. These were brigade surgeons, appointed by the President after taking an examination. David Prince was one of the first of the brigade surgeons assigned to McClellan's Army. The attempt of these federal appointees to exert their authority over the state-appointed regimental officers was difficult at first, but Tripler and McClellan backed them up.

Tripler planned a field medical operation with specially trained troops to handle the evacuation and treatment of field casualties. Prior to this, if a man in a regiment was wounded, his comrades were supposed to drop their guns and help him, or he was left to the resources of other wounded men. The few ambulances available were under the control of the Quartermaster Department rather than the Medical Department. The wounded were attended in small regimental hospitals where they were under the care of any doctor who happened to have volunteered or have been appointed by a State Governor. Many of these regimental surgeons had no surgical experience or judgment and unfortunately used the excuse of war to perfect their technique of amputation. Tripler emphasized the need of specialized troops who did nothing but medical care, and who were under the supervision of men like Prince—outstanding members of the medical profession, appointed after examination.[11, 12]

McClellan's Army engaged in the Seven Days' Battles around Richmond in June and July, 1862. After almost reaching Richmond, McClellan had to conduct what he called a "change of base" but what was really a retreat. In the last of the Seven Days' Battles, Malvern Hill near the James River, on July 1, many of the wounded had to be left behind. The Official Records of the War of the Rebellion contain the following letter:[13]

> "In vicinity of Battlefield of July 1 near James River, Thursday, July 3, 1862
>
> Brigadier General Stuart, Commanding C.S. Army
>
> SIR: It is proper for me to state to you that while the U.S. Army was retreating during the night of the first of July, it became known to me that a hospital depot containing over a hundred men too severely wounded to follow the army would be left without any care whatever.
>
> I chose to remain with them to do what I could for them, and the following enlisted men volunteered to remain with me and throw themselves upon the magnanimity of the government of the Confederate States. . . .
>
> All but the first three of these and the fifth making four in all were taken from me yesterday as prisoners of war.
>
> We are without food, and if attendants and food are not sent us, we must starve.
>
> Respectfully yours,
>
> David Prince, Brigade Surgeon, U.S. Volunteers."

Prince and his men were taken to the Libby Prison in Richmond. As a medical officer, Prince could have been immediately exchanged under the enlightened rules early in the war, but he chose to remain with the men and care for them. He was finally released and exchanged late in 1862 or early in 1863. Under the terms of exchange, he could not re-enter military service, but he did serve briefly as a draft board surgeon in the summer of 1863.[14]

Reunited with his family, Prince returned to medical practice in Jacksonville and to medical organizations. He was elected Vice-President of the American

Medical Association at the 14th annual meeting in Chicago in June, 1863. His second son, John A. Prince, was born in October, 1863, a daughter Stella having been born in 1858. In 1864, at the Illinois State Medical Society, he presented the Report on Plastic Surgery which includes some of his famous cases. The war as such is not mentioned in this report, but he did include one or two war cases in his later Report on Orthopedic Surgery. Prince's type of surgery was not suited to the immediacies of the Civil War. It would now be called Reconstructive or Rehabilitative Surgery. In the Civil War, the government did not recognize an obligation to restore men to health before discharging them from Service. If they were not well enough for duty and were able to travel, they were merely discharged and sent home. Prince operated on war veterans privately, but not at government expense or with government sanction. After the war, he documented some of his observations and recommendations for the U.S. Sanitary Commission.

Surgical Infirmary Founded

In 1867, he founded the Jacksonville Surgical Infirmary, more commonly known as the David Prince Sanitarium. This was located on South Sandy Street, just off the Public Square. Operating room facilities were not available in Jacksonville before this and Prince realized the need for something more than just an office. He had to have surgical facilities, bed care under the supervision of trained persons, and later (with Listerism) special equipment for carbolic acid sprays. Still later, he incorporated into the Infirmary a system of filtered air, with the operating rooms sealed off from the rest of the building by air-locks.[15] Prince's surgical practice grew over the years and the Infirmary was a source for training of many surgeons including Prince's sons, Arthur and John, Dr. W. H. H. King, Dr. G. V. Black, Dr. William Hairgrove, and Dr. G. N. Kreider. The day-to-day nursing care at the Infirmary was under the supervision of a Mrs. Howell, the Matron, affectionately known as "Auntie Howell" to the Prince grandchildren.

Arthur E. Prince, after graduating from the Medical Department of the University of the City of New York in 1877, took postgraduate work in ophthalmology and otolaryngology in Europe and then became associated with his father at the Infirmary in these specialties. A brilliant surgeon and innovator in his own right, he was widely known and practiced in Jacksonville and Springfield until his death in 1930. The second son, John A. Prince, graduated from the University of Michigan Medical School in 1887, worked with his father until David Prince's death, and then took further surgical training in Europe. He practiced general surgery in Springfield, dying in 1911.

Infirmary's Magnitude

Some idea of the magnitude of the Prince Infirmary in the 1880's is obtained from an article in the Jacksonville Journal which described the Infirmary and said that 3000 patients a year were treated there—half in David Prince's general surgical department, and half in Arthur's EENT department.[16]

David Prince continued to be active in medical societies. Between 1867 and 1889 he is listed as having presented papers at the Illinois State Medical Society, the AMA, the American Surgical Association (of which he was a charter member), and at International Medical Congresses in London and Copenhagen. Subjects included Plastic Surgery, Orthopedic Surgery, Palatoplasty (with description of instruments invented by G. V. Black), cooling sprays for local anesthesia in Oral Surgery (again with G. V. Black), employers' liability for injured railroad employees, Colles' fracture (which Kellogg Speed says still contains good advice even though it was written 20 years before x-rays), antiseptic surgery, gynecology, physical therapy, and operating-room design. In addition to this, he was active in community affairs, a member of the Board of Education and the Library Board, and a Director of several companies.

Prince's greatest published work is a series of reports made for the Illinois State Medical Society in 1864, 1867, and 1871 on Plastic and Orthopedic Surgery. These have been bound into one volume along with his 1876 paper on Palatoplasty and his 1877 paper on Diseases of the Joints.[17] In these papers, he carefully

documents and reviews the literature, citing references and presenting the history of the subject. Then he includes cases of his own, with a detailed description of what he did and how he did it. He documents his own errors and points out without apology how he might have avoided them.

Other surgeons have commented upon the importance of Prince's work. Dr. Carl E. Black checked all of his citations and finds that Prince quoted accurately and in detail from 184 authors in 569 references, including many in French and German.[18] Dr. Kellogg Speed says of Prince, "On review, the brilliance of this surgeon stands out emphatically amongst his colleagues."[19] Drs. F. W. Merrifield and W. W. Dalitsch, writing on the history of Plastic Surgery, include Prince as one of the founders "blazing a trail through an unexplored territory."[20]

Prince was active up until a few days before his death. After seeing patients on December 13, 1889, he had a chill. Pneumonia followed, and he lived only until December 19. A few moments before he breathed his last, he asked Mrs. Howell, matron of the Sanitarium, how his patients were.[21] His death was mourned by citizens, patients, physicians. Among his many tributes was one from a group of Negro citizens of Jacksonville who said that David Prince treated all men as equals. What could be a better epitaph for a surgeon who devoted his life to Medicine and to Freedom?

References

1. Walsh, J. J.: *History of Medicine in New York: Three Centuries of Medical Progress. Vol. II.* New York: National Americana Society, Inc., 1919, pp. 351-357
2. Juettner, Otto: *Daniel Drake and His Followers.* Cincinnati: Harvey Publishing Co., 1909, page 164
3. Rammelkamp, C. H.: *Illinois College—A Centennial History.* New Haven: Yale University Press, 1928, pp. 95-100
4. Zeuch, L. H. ed.: *History of Medical Practice in Illinois. Vol. I—Preceding 1850.* Chicago: Illinois State Medical Society, 1927, page 546
5. Reference 2 above. Page 396
6. Bateman, Newton, and Selby, Paul, ed.: *Historical Encyclopedia of Illinois.* Chicago: Munsell Publishing Company, 1906, page 141
7. Eames, Charles M.: *Historic Morgan and Classic Jacksonville.* Jacksonville, Illinois: Daily Journal Steam Job Printing Office, 1885, pp. 117-118
8. Reference 7 above. Pp. 120-121
9. Reference 4 above. Page 395
10. Reference 7 above. Pp. 147-148
11. Adams, G. W.: *Doctors in Blue: The Medical History of the Union Army in the Civil War.* New York: Henry Schuman, 1952, pp. 59-73
12. *War of the Rebellion: A Compilation of the Official Records of the Union and Confederate Armies.* Washington 1880-1901: Series I, Volume 5, page 79
13. Reference 12 above. Series II, Volume 4, page 178
14. Reference 12 above. Series III, Volume 5, page 904
15. Black, C. E.: David Prince. *Surgery, Gyneecology, and Obstetrics* 63: 242-244 (Feb. 1, 1934)
16. *Jacksonville Journal,* December 18, 1889
17. Prince, David: *Plastics and Orothopedics: Being Editions of Three Reports Made to the Illinois State Medical Society in the Years, Respectively, 1864, 1867, and 1871.* Philadelphia: Lindsay and Blakiston, 1871, 239 pages
18. Black, C. E.: David Prince—Plastics and Orthopedics in the Mississippi Valley, read before the Western Surgical Association, Kansas City, Mo., December 1936. (Manuscript available in Jacksonville Public Library.)
19. Speed, Kellogg: "General Surgery" in Davis, D. J.: *History of Medical Practice in Illinois. Vol. II. 1850-1900.* Chicago: Illinois State Medical Society, 1955, chap. 8, page 207
20. Merrifield, F. W., and Dalitsch, W. W.: "Plastic and Reconstructive Surgery" in Davis reference 19 above, chap. 16, page 338
21. *Jacksonville Journal,* December 20 and 21, 1889

RESULTS OF "OPERATION HEAD START" IN CHICAGO

An important report on the results of Operation Head Start in 1965 was disclosed by Dr. Irving Abrams, Medieal Direetor of the Chicago Board of Edueation and Director of Operation Head Start for Chieago.

Dr. Abrams reported the following:

A total of 13,720 presehool children, ages 4½ to 5½ years, were given comprehensive histories and physical examinations, hearing tests, vision tests, quantitative hemoglobin, urinalysis and one or two inoeulations, as needed. Parents were required to attend with the child in order to make the examination effeetive. This was the only program in the country in whieh parents were required to be present.

Of the 13,720, 38.08% showed defeets of one sort or another, excluding vision defects, hearing defects and excluding mental and emotional disturbanees. The table below shows the defects in this young age group in order of frequency. Please note that emotional disturbanee and mental retardation are not charted beeause these two conditions are suspeet and eannot be diagnosed in one visit.

FIRST 10 CAUSES

Type of Defect or Finding	No. of Preschool Children Records Reviewed For This Defect	No. of Defects	Percent
1. Dental (1 or more decayed teeth)	2376	877	36.8
2. Anemia (10.90 grams hemoglobin or less)	2319	779	31.6
Anemia (9.9 grams hemoglobin or less)	2319	198	8.5
3. Vision losses and defects	14593	1548	10.4
4. Infected tonsils	13720	771	5.6
5. Hearing losses	17115	943	5.5
6. Hernias (mostly umbilical)	13720	342	2.4
7. Heart murmurs	13720	314	2.2
8. G. U. (mostly phimosis)	Not Charted	228	1.6
9. Emotional disturbance	Not Charted	—	—
10. Mental retardation		—	—

The table below shows the results of the tests for hearing:

AUDIOMETRIC TESTING

	Number	Percent
Number of Educational Centers Visited by the Testers	129	
Number of Children Tested in these Centers	17,115	
Number of Children with Borderline Hearing Loss	706	
Number of Children with Significant Hearing Loss	237	
Total Number of Children Found with Hearing Loss	943	5.5%

The next table shows the results of the vision tests:

Number of Educational Centers Visited By Testers	Number of Children Actually Tested	Number of Children Not Tested Because Unable	Number of Children Already Wearing Glasses	Per Cent	Total Number of Children Seen By Testers
130	14,593	1,246	218	1.47	16,057

Number of Children With External Defects	Number of Children Who Failed Vision Test	Number of Children Who Failed to Pass The Vision Test		Total Number of Children With Eye and Vision Defects	Per Cent
		In One Eye	In Both Eyes		
318	1,330	638	692	1,330 + 218 = 1,548	10.4

The major causes of vision test failures in the 4½ to 5½ year old group are refractive errors, consisting of myopia, hyperopia and astigmatism.

Regarding dental defects, 36.8% showed one or more decayed teeth.

The heights and weights of these children compared favorably with the averages around the country.

Dr. Walter M. Whitaker, President of the Illinois Academy of Pediatries, has stated that Operation Head Start will be expanded in 1966 with more funds being made available under the Elementary and Secondary Edueation Act and the Offiee of Economic Opportunity.

This information is being made available to all physicians who are eoncerned with the care of ehildren in this state, so that they will be more fully eognizant of the problems relating to child care. It is hoped that this information will result in an increased participation of the physieians of the Illinois State Medical Soeiety, in Operation Head Start in 1966.

Harvey Kravitz, M.D.

FREE LITERATURE AVAILABLE TO MEMBERS

The various departments of the Illinois State Medical Society are offering interesting and informative literature to the membership, free of charge. Fill in the coupon below with the quantity desired on the line following the numbers.

1. Dr. Sims Guide to Voluntary Health Agencies
2. Home From the Hospital
3. Physicians' Placement Brochure
4. Students' Medical Loan Fund
5. Profile of Dr. Sims
6. Disaster Manual for Hospitals
7. Rx For a Good Meeting
8. Scientific Speakers Bureau Roster (for County Society meetings only)
9. Know Your Politics
10. How the Opinion Maker Makes Opinion
11. AMPAC's Political Education Series: "Know Your Community"; "Political Party Structure"; "The Precinct Organization"; "Working Within the Party"; "The Medical PAC Structure"; "The Candidate Support Committee"; "The Political Campaign"; and "Politics with the Woman in Mind."
12. Drug Abuse: The Empty Life
13. Prescribing and Dispensing of Narcotics Under Harrison Narcotic Law
14. Narcotics Addiction: Official Action of the American Medical Association
15. First Facts About Drugs
16. Narcotic Drug Addiction
17. Rehabilitation in Drug Addiction
18. Facts About Narcotic Drug Addiction
19. Prevention and Control of Narcotic Addiction.
20. The Official Position of the U.S. Bureau of Narcotics on Handling Narcotic Addicts
21. Interprofessional Code for Physicians and Lawyers of Illinois

1.———	8.———	15.———
2.———	9.———	16.———
3.———	10.———	17.———
4.———	11.———	18.———
5.———	12.———	19.———
6.———	13.———	20.———
7.———	14.———	21.———

Mail to:

Illinois Medical Journal
360 North Michigan Avenue
Chicago, Illinois 60601

NAME _____

ADDRESS _____

CITY_____ STATE_____ ZONE_____



OVERDOING THE UNUSUAL

Arthur Grame presented his point of view on the interesting patient syndrome in the September (1965) *Archives of Internal Medicine.*

He noted that less than one-third of the articles in three widely read medical journals dealt with the common illnesses, such as heart disease, stroke, cancer, accidents and diabetes. There has been a switch in medical writing to the mystifying, curious and unique. To keep up with current trends, many department chiefs are readmitting the more interesting patients to allow each new batch of students to reexamine them and perform endless laboratory procedures. Examples include hereditary telangiectasia, abdominal epilepsy, hypo-kalemic diurnal toxity, Cushingoid facies due to bronchial carcinoma, Boeck's sarcoid and Hashimoto's thyroiditis. One of these patients spent 150 days in the hospital and notes were added to the chart by 72 different doctors.

What effect does this have on the patient? The majority enjoy it. According to Grame, some build up tremendous ego strength in what might otherwise be a chronic, depressing illness. Others become so knowledgeable that they are able to carry on a scientific discussion with the authorities. Still others enjoy the fact that the economic burden of the illness has been removed by the desire of the hospital to use him as a technical case. Now and then they team up to form clubs such as the Multiple Sclerosis Club or the Ileostomy Club.

The main objectives are that the ordinary illnesses are being slighted and the young physician is misled into thinking that the only enjoyment in the practice of medicine is the care of the rare case.

T. R. Van Dellen, M.D.

MEDICAL QUACKERY

"Physicians, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms."

Is this a quote from proceedings of the American Medical Association's Clinical Convention in Philadelphia in December?

The meeting was in Philadelphia, but the year was 1847!

So you see, from its very inception 118 years ago, the American Medical Association has been battling quackery and it is dedicated to a continuation of this warfare against wasting the nation's health and its health care dollar . . . of fighting fraud at the bedside of ill and desperate people.

For, as long as there are human beings, there will be human nature . . . and quacks

—pretenders to ability they don't possess —to take advantage of the fact.

The health quack is not so easy to spot these days. The stovepipe hat and the pitchman's hawking have gone. In their place are their space-age counterparts, the suave, apparently sophisticated supersalesmen with the Madison Avenue manners.

These merchants of menace, more insidious and unscrupulous than ever, have many new products, worthless diet fads, worthless food supplements, worthless eosmetic devices and treatments, worthless "cures" for everything—even into the area of brain-damaged children and other mental illness.

They bilk the undiscerning—the uninformed, the desperate, the unsuspecting of all ages—of millions of dollars a year. The estimates of the costs of medical quackery are at best calculated guesses, but they have gone as high as a billion dollars a year. And one authority in the field of quack-fighting has stated that "medical quackery each year costs more lives than all crimes in the United States."

It is this cost of life—and health—that has placed America's physicians in the front lines of the war on quacks. It is the insidious side effect of quackery with which medicine concerns itself—the delay in proper medical care that may cost life itself.

It is for this reason, too, that the medical profession is dedicated to education of the people about cultism—chiropractic and the other health sects that turn their backs on scientific medicine.

The House of Delegates of the American Medical Assoeiation said in 1933:

> "Either the theories and practices of scientific medicine are right and those of the cultist are wrong, or the theories and praetices of the cultists are right and those of scientific medicine are wrong."

And in 1961, it said:

> "There can never be a majority party and a minority party in any science . . ."

After the quaek or the cultist has extracted his pound of flesh—after the damage is done and after the sick may have become the dying because of the delay in proper care—scientific medicine usually is called upon to pick up the pieces.

Medieine has tried and will continue to try to do that job, too, but how mueh easier the job would have been—how many lives would have been saved—if . . .

Reprinted with permission of the AMA's Committee on Quackery

CURRENT DEVELOPMENTS IN CULTURING FOR BETA HEMOLYTIC STREPTOCOCCI

A report of the effectiveness of cotton-tipped swabs as a simple method for transporting eultures for beta-hemolytic streptococci was made by Dr. Burtis B. Breese in the October, 1965 issue of *Pediatrics*. The author showed that 100% of beta-hemolytic streptococci will remain viable for one week and over 90% for periods up to one month if cotton-tipped swabs are sealed in envelopes. These cultures will give results comparable to those obtained when swabs are immediately plated. Breese states that this technique eliminates the need for dacron-tipped swabs, broth, and special transport media. Doctors can transport throat cultures to their laboratories or mail them to laboratories without haste and without the worry that the specimen would fail to survive.

The problem of obtaining throat cultures for beta-hemolytic in the emergency room of private hospitals has been stressed by Levin. Many house officers as well as private physicians often fail to take throat cultures because of the large expense to the patient. These patients are often given unnecessary injections of penicillin for cases of tonsillitis or pharyngitis regardless of viral or bacterial origin.

Harvey Kravitz, M.D.

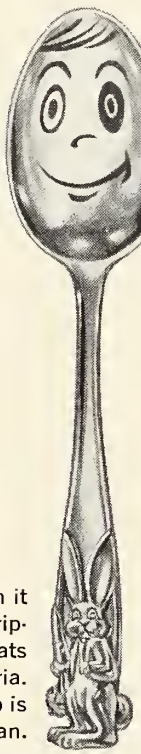
References

1. Breese, B. B., Cotton-Tipped Swabs for Transporting Cultures of Streptococci. *Pediatrics* 36:599, 1965.
2. Levin, P. A., Antibiotic Prophylaxis. *Amer. J. Dis. Child.* 110:336, 1965.

PENTID®-SULFAS FOR SYRUP

SQUIBB BUFFERED PENICILLIN POWDER WITH SULFADIAZINE, SULFAMETHAZINE, AND SULFAMERAZINE

the fruit punch that packs a wallop



Pentid-Sulfas for Syrup is a real knock-out when it comes to good taste. And, with a single prescription, you provide an anti-infective that combats both gram-positive and gram-negative bacteria. Notable for its economy, Pentid-Sulfas for Syrup is everybody's choice, patient, parent and physician.

Contraindications: Contraindicated in patients sensitive to sulfa or penicillin, pregnant females at term, premature infants, newborns during first week of life. **Precautions:** Watch for hypersensitivity reactions and overgrowth of nonsusceptible organisms. Observe usual precautions for sulfonamide therapy: adequate fluid intake; force fluids if urine volume is low; maintain urinary pH of 7 or higher; use only after critical appraisal in patients with liver or renal damage, urinary obstruction, blood dyscrasias. **Adverse Reactions:** Anaphylactoid shock (rare), G.I. disturbances, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, urticaria, purpura, hematuria, crystalluria, conjunctival and scleral varicula, petechiae may occur. **Dosage:** Daily pediatric dosage should supply 65-100 mg. trisulfapyrimidines per pound body weight in divided doses q. 4 to 6 h. **Supply:** Pentid-Sulfas for Syrup when prepared, provides 80 cc. (16 doses) or 150 cc. (30 doses) of fruit-flavored syrup providing in each 5 cc. teaspoonful 125 mg. (200,000 u.) potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine.

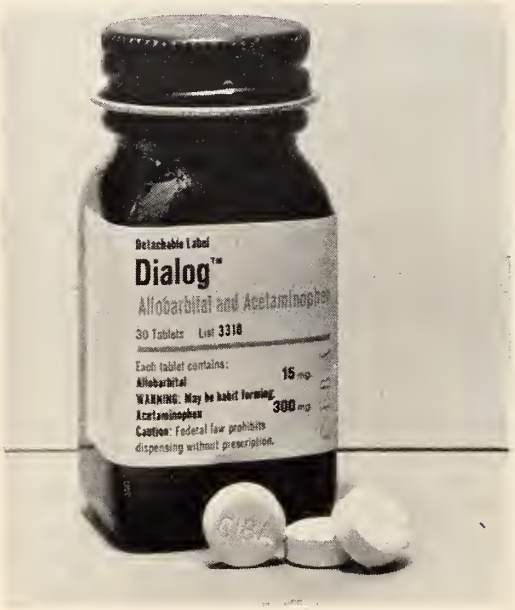
Now . . . **NEW PENTID® '400'—SULFAS FOR SYRUP** (buffered penicillin powder with sulfadiazine, sulfamethazine, and sulfamerazine each 5 cc. providing 250 mg. [400,000 units] potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine). Available in 16-dose (80 cc.) and 30-dose (150 cc.) bottles.

For full information, see Product Brief.

SQUIBB Squibb Quality—the Priceless Ingredient

Rx Reviews and New Products

New Analgesic Helps Tension Headache



A new sedative and analgesic/antipyretic in a single tablet formulation has been developed by Ciba Pharmaceutical company to help sufferers from tension headache and neuralgia.

Called Dialog, the new prescription compound relieves the pain of simple headache, neuralgia, myalgia, musculoskeletal pain, dysmenorrhea, bursitis, sinusitis and fibrositis. It is also indicated to relieve discomfort and reduce fever due to respiraory infections and influenza.

Dialog combines the sedative action of allobarbital with the analgesic and antipyretic effects of acetaminophen (APAP). This combination acts together to raise the patient's pain threshold, interrupt the pain mechanism and temper emotional stress.

Dialog is well tolerated, non-narcotic and contains no phenacetin or salicylates. Even in patients sensitive to aspirin, Dialog can be prescribed with virtually no risk of gastrointestinal irritation or hidden bleeding and has no adverse effects on the kidneys.

Searle Develops New Birth Control Pill

A more effective new chemical compound birth control pill, 1 mg. Ovulen, has been cleared for marketing in the United States by the Food and Drug Administration, according to its manufacturer, G. D. Searle & Company. It was initially introduced in 1963 in the British Isles and currently is marketed in nearly every nation in the Free World.

1 mg. Ovulen is described chemically as ethynodiol diacetate combined with mestranol. It has as an active ingredient a single milligram. The other active ingredient is one tenth of a milligram.

Asthmatics Require Better "Pre-Op" and "Post-Op" Care

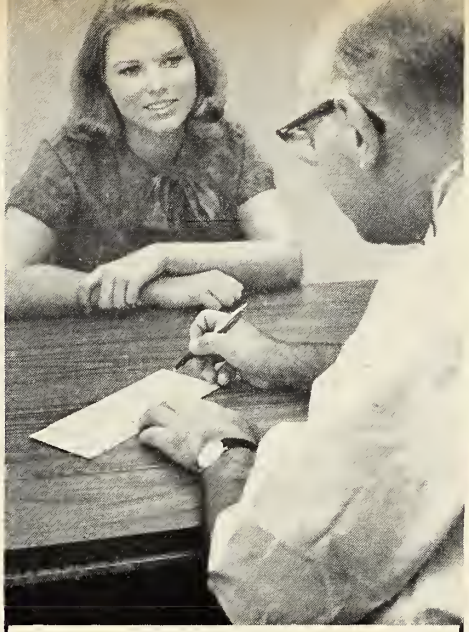
More diligent care before and after surgery should be given asthmatic patients requiring anesthesia in order to reduce the 13-25 per cent of the postoperative mortalities which are ascribed to respiratory complications, Dr. Martin I. Gold states in *E. E. N. T. Digest* (27:63, 1965).

Isuprel (isoproterenol), a bronchodilating agent, is cited as most beneficial in relieving bronchospasm, in preference to aminophylline, ephedrine, antihistamines and iodides. If bronchospasm should occur during surgery, Isuprel by intravenous drip is recommended or it can be nebulized through an endotracheal tube.

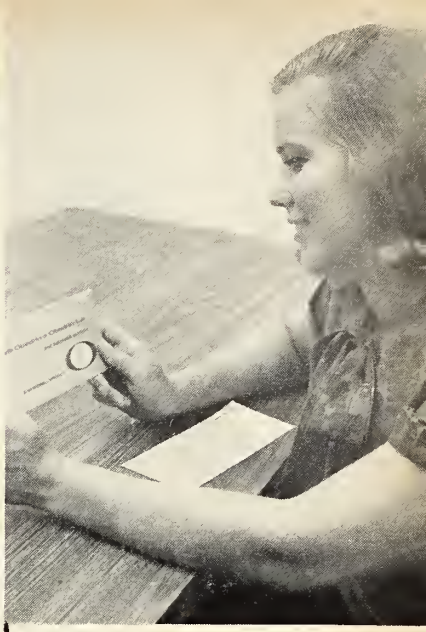
Other premedication suggested by Dr. Gold, who is associate professor of anesthesiology at the University of Maryland School of Medicine, are pentobarbital or secobarbital for sedation and an anticholinergic. Since all smokers are assumed to have chronic bronchitis, he stresses the importance to asthmatic patients of discontinuing smoking before surgery. They should also be taught to cough up secre-



1. YOUR SUPERVISION



2. "TRICKLE RELEASE" OBEDRIN-LA



3. OBEDRIN MENU PLAN

A WEIGHT CONTROL PROGRAM YOUR PATIENTS WILL STAY WITH . . . AND FEEL BETTER

1. YOUR SUPERVISION orients the patient to the need, goals and course of weight reduction . . . regular checkups confirm progress and support patient's morale.

2. OBEDRIN-LA: 1 tablet daily "trickle releases" medication for all-day appetite suppression.

3. OBEDRIN MENU PLAN: . . . aids weight reduction . . . provides a plan for necessary nutritional support and helps patients establish better eating habits.

Write today for free starter doses and Menu Plans, or contact your Massengill Representative.

DOSAGE is 1 tablet daily, usually at 10 a.m.

SUPPLIED in bottles of 50 and 250 tablets, on prescription only.

CAUTION: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage. Use with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution during pregnancy, especially in the first trimester.

LONG ACTING

Obedrin®-LA*

"TRICKLE RELEASE" TABLETS

Each tablet contains Methamphetamine HCl*, 12.5 mg.; Pentobarbital*, 50 mg. (Barbituric Acid derivative; Warning: May be habit forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Niacin, 10 mg. *U. S. Pat. Nos. 2,736,682; 2,809,916; 2,809,917; 2,809,918 and pat. pending.

MASSENGILL The S. E. Massengill Company, Bristol, Tennessee

New York • Chicago • Dallas • Kansas City • San Francisco

tions thoroughly every morning and to use postural drainage.

Postoperatively, Dr. Gold notes, pharyngeal and tracheal suction are important, especially in elderly patients who usually have poor cough reflexes. Humidified air should be breathed in order to thin viscous secretions. If bronchospasm should occur, "intermittent positive pressure breathing with inhalation of nebulized isoproterenol should be started."

Isuprel is manufactured by Winthrop Laboratories.

New Intestinal Clamp

The Hawkins Intestinal Clamp has as its tips, smooth slightly cupped discs which offer a larger tissue gripping area. The radius of concavity of one tip is slightly less than the mating convex tip, thus providing greater holding power in the center, diminishing as it approaches the outside of the tips. There is no sharp line of demarcation between the gripped zone and the surrounding soft tissue, thus reducing the risk of tissue injury. The clamp, 6-½" long is made of stainless steel, with a box lock.

Descriptive literature is available from J. Sklar Mfg. Co., Inc., 38-04 Woodside Avenue, Long Island City, N.Y. 11101.

Northwestern Scientist Disputes Conventional View of Blood Transfusion Reaction Cause

Blood group antibodies which trigger severe and sometimes fatal reactions to blood transfusions are formed not by genetic factors but by microorganisms living within the body, a Northwestern University microbiologist reported recently.

The finding indicates that such antibodies can be chemically neutralized so that a patient may be given any of the major blood types—A, B or O—in a transfusion. If "anti-blood group" antibodies were inherited, as believed in the conventional view, this neutralization would be impossible.

Dr. Georg F. Springer, professor of microbiology at Northwestern's Medical School and director of the immunochemistry department at Evanston Hospital, reported these conclusions in a paper presented at the Hartford Foundation Conference on Blood Groups and Blood Transfusions held at the New York University School of Medicine.

He described his findings as the first experimental evidence that bodily environment and not heredity is basically responsible for transfusion reactions occurring when a person with one blood group is injected with blood of another human group.

In recently completed experiments, Dr. Springer's research group fed large amounts of killed blood group-active intestinal bacteria to infants. The children consequently produced strong anti-blood group antibodies sooner and in much larger amounts than they would have ordinarily, he said.

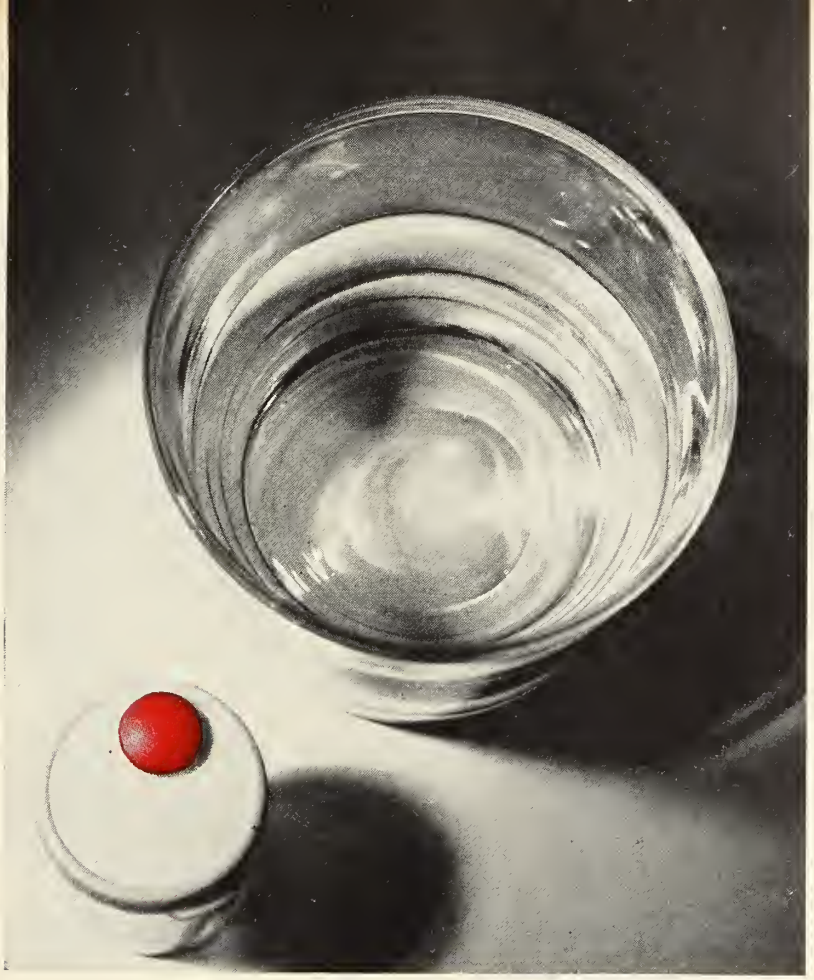
In previously reported experiments, Dr. Springer found that chickens raised in a microbe-free environment failed to develop blood group antibodies (which they would have been expected to do if the genetics-based theory were correct.) The experiments were conducted jointly with Dr. R. Horton at Walter Reed Army Medical Center in Washington, D.C. Chickens were used because they produce the same type of blood group antibody as do humans.

Another finding reported in the paper was that the chemical substances composing the various blood groups are found in virtually every living organism. This includes even "bloodless" bacteria, viruses and plants. The previous view was that blood group substances existed only in the blood of Man.

Dr. Springer found that the blood group structures are sugars. Surprisingly similar structures are found in the membrane wrapping which encases bacteria as well as animal and human cells, he said.

Small groups of these sugars might be used to neutralize blood group antibodies and to halt reactions caused by infusion of a wrong blood type, he said.

One physiological function of the blood group substances appears to be as a receptor for antibodies, said Dr. Springer. In other experiments, he has shown that blood group substances M and N also act as receptors—and apparently as the point of attachment to human cells—for the influenza virus.



one mid-evening

It's made for b.i.d.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE
300 mg FILM COATED TABLETS

demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg of demethylchlortetracycline HCl.

Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

6555-2355R

Meeting Memos



May 16—Depression and suicide, drug reactions, surgery, continuing education and diseases of the connective tissue systems will be featured on the annual full-day alumni seminar program of the University of Illinois College of Medicine.

The program, held at the College of Medicine, 1853 West Polk Street, begins at 9:00 a.m. and is open to all alumni of the College of Medicine at no charge.

An evening session at the Hotel Sherman will feature a 6:00 p.m. cocktail hour followed by the Alumni Association's annual banquet at which the speaker will be Dr. Charles Berry, physician to the NASA astronauts.

Further information can be obtained through the University of Illinois Medical Center Campus Alumni Association Office, 124 DMP, 1853 West Polk Street, Chicago.

June 8—Forest Hospital, 555 Wilson Lane, Des Plaines, will present "Unanswered Questions of Stress and Adaptation" as the conclusion of its guest lecture series, at 8:00 p.m. The speaker will be Henry Brosin, M.D., Professor and Chairman, Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pa.

June 23-24—The 23rd annual meeting of the American Geriatrics Society will be held at the Palmer House, Chicago. Speakers include Irving S. Cooper, Ph.D., M.D., Clinical Professor of Neurosurgery, New York University of Medicine; C. Walton Lillehei, M.D., Professor of Surgery, University of Minnesota Medical School; C. Douglas Talbott, M.D., Director, Cox Coronary Heart Institute, Kettering, Ohio; Michael DeBakey, M.D., Professor and Chairman, Cora and Webb Mading Department of Surgery, Baylor University College of Medicine, Houston; Charles L. Hudson, M.D., President-elect, AMA; Philip R. Lee, M.D., Assistant Secretary for Health and Scientific Affairs, Department of HEW; and Eric Hodgins, B.S., D.Lit., distinguished editor and novelist, author of "Mr. Blandings Builds His Dream House" and "Episode."

There will be no registration fee for attending the scientific sessions, but a charge of $3.00 will be made for the luncheon.

June 26—The 8th annual preconvention session on school health will be held at 7:30 p.m. at the Palmer House, Chicago. This session will offer outstanding speakers from medicine, science, and education on various aspects of school health programs. For additional information contact the Department of Health Education, American Medical Association, 535 North Dearborn Street, Chicago 60610.

June 28-29—The Michael Reese Hospital Staff Alumni Association will hold a reunion banquet at the Standard Club. The cocktail party will start at 6:30 p.m. The reunion program will continue the next day with morning clinic and lunch at the Michael Reese Hospital and Medical Center. Reservations can be made with the Alumni Association, 29th & Ellis Avenue, Chicago 60616.

LOOKING FOR A PLACE TO PRACTICE?

PLACEMENT SERVICE LISTS OPENINGS

Following is a sample of the more than 150 openings for general practitioners listed with the Illinois State Medical Society's Physicians' Placement Service. Interested physicians who register with the service will be provided with a complete list of openings. Inquiries and comments should be directed to: Mrs. Robert Swanson, Secretary, Physicians' Placement Service, Illinois State Medical Society, 360 North Michigan Avenue, Chicago 60601, STate 2-1654.

MARION COUNTY: Salem. Population 6200. Estimated population of trade area—15,000. Only 4 physicians, ages 52, 55, 57 and 74. In the past there have usually been 7 or 8 physicians. Present number completely inadequate according to county medical society. Salem Memorial Hospital located here. 45 beds. Citizenship not required for staff membership. 65 miles from St. Louis, Mo. 2 prescription drug stores; third store under construction. Adequate office space and housing. Sources of income: manufacturing, petroleum production and agriculture. 20 Protestant and Catholic churches. Nearest Jewish temple 18 miles. Grade and high schools. Organizations: Rotary, Elks, Masons, VFW, American Legion, Lions, Moose, BPW, etc. Recreational facilities: golf club with swimming pool, park, soft ball, etc. 15 miles to Forbes State Park. 20 miles to Carlyle Lake, nearing completion. Only 5% of the county on IPAC. At least one general practitioner and one surgeon needed. 254 miles south of Chicago.

MARSHALL COUNTY: Henry. Population 2300. One of two physicians leaving after nine years to enter practice in his wife's home town. Replacement urgently needed. Nearest hospital, St. Margaret's in Spring Valley, 25 miles. 35 miles from Peoria. 1 prescription drug store. Doctor who is leaving owns one-story, 7-room building, remodeled in 1957; will rent or sell with or without equipment. Doctor's house for sale if desired. Sources of income: agriculture, Goodrich plant, fertilizer plant to be opened soon. Henry is 12 miles from fast-growing Hennepin area. Protestant and Catholic churches. Public and parochial schools. Grade and high schools. Country Club at Lacon, 7 miles.

HANCOCK COUNTY: Nauvoo; population 1100 plus over 200 girls enrolled at St. Mary's Academy. Estimated population of trade area: 4000. After November 1, 1965 town was without a resident physician. Nearest physician at Hamilton, 12 miles. Nearest hospitals at Ft. Madison and Keokuk, Iowa—12 miles. Nearest large city—Quincy, Illinois—population 50,000—50 miles. One prescription drug store. Ambulance service provided by local funeral home. Office space available. Equipment of former physician for sale if desired. Modern homes available at reasonable rent. Financial assistance could be arranged if desired. Predominant nationality of residents—English and German background. Principal sources of income: agriculture and industry. Churches: Catholic, Lutheran, Methodist, Presbyterian and Mormon. Grade and high schools—public and parochial. Nearest college at Carthage—25 miles. Organizations: Chamber of Commerce, Lions Club, American Legion, VFW, etc. Nearest golf club and swimming pool at Keokuk, Iowa. Nauvoo is beautifully located on the Mississippi River and is one of the most historical towns in the Middle West. Nauvoo Restoration Inc. has been incorporated for the purpose of restoring a portion of the old city. One million dollars has been spent in the preliminary steps of the historic restoration. Population expected to increase to 5,000 by 1980, due to increased attractions for tourists.

KENDALL COUNTY: Yorkville; population 1800. Estimated population of trade area, 6100. Area without a physician for six months. Nearest physicians at Plano, Oswego and Aurora. Nearest hospitals at Aurora, 12 miles. Population of Aurora, 70,000. Two local prescription drug stores. Ambulance service provided by funeral homes. Completely equipped medical facility available. Financial assistance available if desired. Sources of income in area: agriculture, industry and retail business. Churches: Methodist, Lutheran, Congregational and Catholic. Grade and high schools. Nearest college at Aurora, 12 miles. Active organizations include Masonic Lodge, Eastern Star, Lions Club, Women's Club, VFW, Businessmen, J. Cs., American Legion, Scouts, etc. Nearby recreational facilities: golf, swimming, fishing and boating. 2 excellent banks. Town has formerly supported 3 physicians. County medical society anxious for one or more physicians to locate here.

NEWS and ANNOUNCEMENTS



Loretto Hospital Begins Expansion Program

Ground-breaking ceremonies, held on March 19, signified the beginning of Loretto Hospital's $4 million expansion program.

Loretto's expansion plan includes construction of two new buildings on Flournoy Street. An eight-story structure will contain four floors of nursing units, administrative offices, doctors' lounge and library, cafeteria, medical records and conference and assembly rooms. The adjoining four-story building will accommodate diagnostic and treatment facilities, a morgue and autopsy room, x-ray and laboratory units and much-needed emergency facilities.

Phase two of the expansion program will be the renovation of the present hospital building. Planned are rebuilding of operating and delivery rooms and rearrangement of offices and the pharmacy, supply and social service departments.

Construction is expected to begin in September or October of this year.

North Shore Opens Halfway Hall

A new "Halfway Hall" for emotionally ill patients at North Shore Hospital, Winnetka opened recently with the transfer of 21 patients to this new section.

A 23 bed unit, the Hall will be occupied by patients whose further improvement may be speeded by freedom to come and go and the assumption of increased responsibility for their own behavior.

The newly furnished wing will also play a "central therapeutic role in patient care," according to Dr. Milton A. Dushkin, medical director. "Residence in it will become an aim of therapy, denoting a substantial achievement in self-directed living," the psychiatrist said.

Transfer to Halfway Hall is the second in a three-step progression of patient occupancy at the hospital, the last of these being residence in the hospital's completely open section, described as a "pre-discharge retreat in which final emotional controls may be achieved before a return to home and community."

The Halfway unit will also be utilized as the residence for those new patients whose condition does not warrant treatment in the hospital's closed section.

Twenty-two Clinics for Crippled Children Listed for June

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will count fifteen general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical, social, and nursing service. There will be six special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 1 Carmi—Carmi Township Hospital

June 1 Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital

June 1 Hinsdale—Hinsdale Sanitarium

June 2 Effingham General — St. Anthony Memorial Hospital

June 2 Lake County Cardiac—Victory Memorial Hospital

June 8 Champaign-Urbana — McKinley Hospital

June 9 Macomb — McDonough District Hospital

June 9 Springfield General—St. John's Hospital

June 10 Chicago Heights Cardiac — St. James Hospital

June 10 Evanston—St. Francis Hospital

June 14 Peoria General—Children's Hospital

June 14 East St. Louis—St. Mary's Hospital

June 15 Chicago Heights General — St. James Hospital

June 16 Rockford—St. Anthony's Hospital

June 16 Bloomington—St. Joseph's Hospital

June 16 Elmhurst Cardiac — Memorial Hospital of DuPage County

June 21 Belleville—St. Elizabeth's Hospital

June 22 Springfield Cerebral Palsy (P. M.)—Memorial Hospital

June 22 Aurora—Copley Memorial Hospital

June 23 Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

June 24 Chicago Heights Cardiac — St. James Hospital

June 28 Peoria General—Children's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Pfizer Laboratories Annual Medical Scholarship Announced

The Medical Department of Pfizer Laboratories, Division of Chas. Pfizer & Co., Inc., announced that it will make available 90 medical student scholarships for the 1966-1967 academic school year.

The scholarship program provides each of the 90 medical schools in the United States with a $1,000.00 scholarship. These scholarships are administered solely by the dean of each medical school, or by a committee established by him.

Selection of the recipient of the scholarship may be on the basis of scholastic record, financial need, or other criteria determined by the individual medical school. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student in each of the medical schools in the United States.

Since their inception in 1962, the Pfizer scholarships have been accepted in each of the medical schools in the United States. In addition to this scholarship, Pfizer has also provided the American Medical Association's Educational and Research Foundation with $350,000 in the past four years for the Foundation's student loan guarantee program.

Appointments

Dr. Joseph B. Kirsner, professor of medicine at the University of Chicago, has been appointed to the United States Public Health Service's National Advisory Arthritis and Metabolic Diseases Council.

The Council makes recommendations to the Surgeon General of the United States on pertinent programs in the U.S. Public Health Service.

One of its major responsibilities is the reviewing of grants to support non-governmental research. The Council also surveys research in its field and recommends action to stimulate additional work.

Members of the Council are selected from leaders in the fields of the fundamental sciences, medical sciences, education and public affairs.

Dr. Kirsner received his M.D. degree from Tufts College Medical School in 1933. He received a Ph.D. degree from the University of Chicago in 1942.

He joined the Department of Medicine of the University of Chicago in 1935, and was named Professor of Medicine in 1951.

He is the author or co-author of 300 publications dealing primarily with clinical and experimental problems in gastroenterology. He was recently elected President of the American Gastroenterological Association.

Dr. C. Frederick Kittle has been named Professor of Surgery and Chief of the Section of Thoracic and Cardiovascular Surgery at the University of Chicago.

A native of Athens, Ohio, Dr. Kittle earned his B.A. degree from Ohio University in 1942. He received his M.D. degree in surgery from the University of Chicago in 1945 and the M.S. in Surgery from the University of Kansas in 1950. After serving his internship at the University of Chicago Hospitals and Clinics and his residency at the University of Kansas Medical Center, he was appointed instructor in surgery at the University of Kansas School of Medicine in 1950. He was made assistant professor of surgery and lecturer in the history of medicine in 1958. In 1959, he became an associate professor.

Dr. Kittle has served as consultant in surgery to the Oak Ridge Institute of Nuclear Studies and to Veterans Administration Hospitals in Wadsworth and Wichita, Kansas and Kansas City, Missouri. He has held a clinical fellowship of the American Cancer Society and a John and Mary R. Markle Scholarship in Medical Sciences.

Dr. Charles B. Huggins, the William B. Ogden Distinguished Service Professor and Director of the Ben May Laboratory for Cancer Research at the University of Chi-

(continued on page 622)

CANDIDATES FOR
"THE MOST EFFECTIVE SUNSCREEN"[1] OR WINDSCREEN

RVP®-ELDER
RED PETROLATUM



RVP-Elder, called "the most effective sunscreen," is also an ideal windscreen.

Constant occupational exposure to sun and wind often causes major discomfort in producing irritating sunburned and windburned skin . . . commonly found in street workers, construction workers, and telephone linemen, to mention a few.

There's reassuring protection and skin comfort for those outdoor workers who use RVP-Elder. Swimmers, golfers and others engaged in outdoor activities can have the same skin protection.

A razor-thin layer of only 10 microns adheres tenaciously to the skin for hours, yet washes off easily with soap and water. Virtually invisible, RVP-Elder is odorless, non-staining, and perspiration and water resistant, even while swimming. No sensitivity has been encountered.

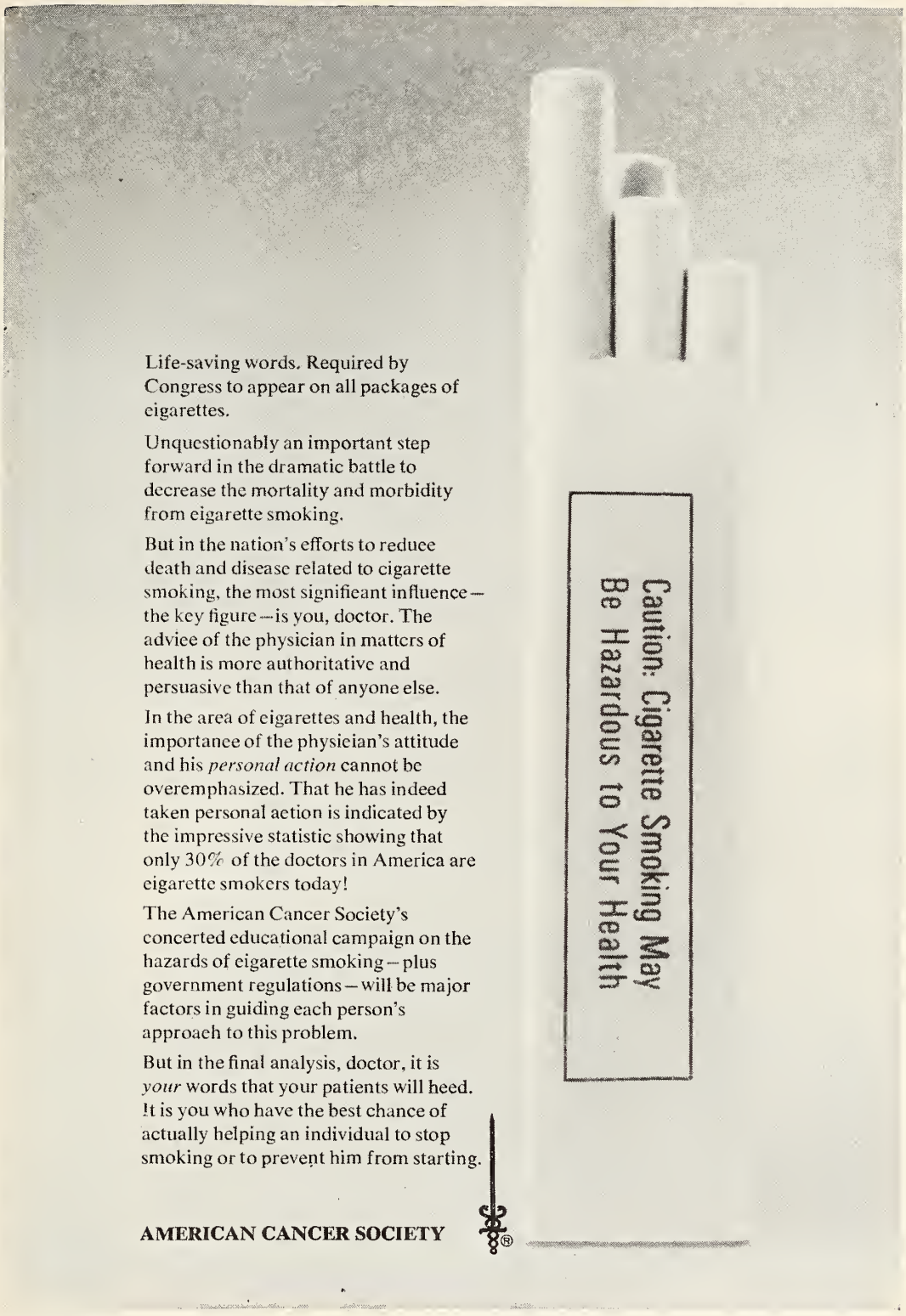
Supplied in 2 oz. and 16 oz.

Write for clinical trial package and absorption spectrum

References: (1) Schoch, A. G.: Current News in Dermatology, August, 1963; (2) Jillson, O. F., and Baughman, R. D.: Arch. Dermat. 88:409, 1963; (3) Cole, H. N., et al.: J.A.M.A. 130: 1, 1946; (4) MacEachern, W. N., and Jillson, O. F.: Arch. Dermat. 89: 147, 1964.

ALSO AVAILABLE: NEW RVP Aerosol, RVP-2, RVPaque, RVPellent

PAUL B. ELDER COMPANY • Bryan, Ohio



Illinois Division, 37 S. Wabash Avenue, Chicago, Illinois 60603

FRanklin 2-0471

cago, was recently awarded an honorary Doctor of Science degree from Trinity College, Hartford, Connecticut.

An internationally known urologist and cancer researcher, Dr. Huggins has previously received honorary degrees from Acadia University, Yale University, Washington University, Leeds University, and the universities of Turin and Milan. He is a member of the National Academy of Sciences and the American Philosophical Society. Among the many other honors which Dr. Huggins has received are the Albert Lasker Award for Clinical Research, the Sigillium Magnum of the University of Bologna, the Gold Medal of the Rudolf Virchow Medical Society, and the Passano Foundation Award.

Dr. Huggins was born in Halifax, Canada, and is a naturalized citizen of the United States. He received the B.A. degree from Acadia University in 1920 and the M.D. from Harvard University in 1924. Before joining the faculty of the University of Chicago in 1927, Dr. Huggins was an Instructor in Surgery at the University of Michigan. He was made an Assistant Professor at the University of Chicago in 1928, an Associate Professor in 1932, Professor of Surgery in 1936, Director of the Ben May Laboratory in 1951, and Ogden Distinguished Service Professor in 1962.

Dr. William Thomas has been appointed to the staff of the department of pathology of the Mount Sinai Medical Center as associate pathologist. Dr. Thomas also holds the rank of assistant professor of pathology at the Chicago Medical School.

A native of Uniontown, Pennsylvania, Dr. Thomas received his M.D. from Boston University School of Medicine, Boston, Massachusetts, in 1955. His internship was spent at Detroit Receiving Hospital, Detroit, Michigan.

TWO MAGIC WORDS

"OPEN ENROLLMENT"

ILLINOIS STATE MEDICAL SOCIETY GROUP DISABILITY PLAN

Look for the Certificate of Extra Membership Privilege Mailed to You

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance
Administrators

9933 LAWLER AVENUE SKOKIE, ILLINOIS PHONES 679-1000

From 1956 to 1960, Dr. Thomas was resident physician in a combined pathology program at Cincinnati General Hospital, Cincinnati, Ohio, and instructor in pathology at the Cincinnati College of Medicine.

Dr. Thomas served as resident physician in clinical pathology at Henry Ford Hospital, Detroit, Michigan, from 1960 to 1961 and as associate pathologist at the Bridgeport Hospital, Bridgeport, Connecticut, from 1961 to 1963.

Dr. Thomas came to Chicago in 1964 and was associate director of pathology at Michael Reese Hospital until his appointment to the Mount Sinai staff.

Dr. Mark M. Ravitch has been named Professor of Surgery and Chief of the Section of Pediatric Surgery in the School of Medicine at the University of Chicago.

Before coming to Chicago, Dr. Ravitch was Professor of Surgery at the Medical School of Johns Hopkins University and Chief of Surgery at Baltimore City Hospital.

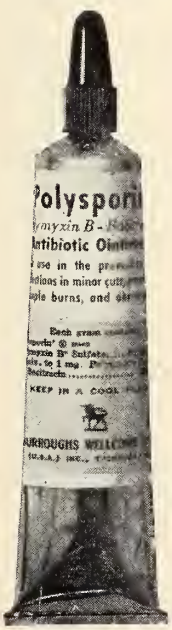
His accomplishments include the development of a nonoperative method of treating certain types of intestinal obstructions in children, improved surgical techniques for correcting congenital chest deformities and clarification and standardization of surgical treatment of hernias in children.

Dr. Ormand C. Julian, attending cardiovascular surgeon, was appointed chairman of the Presbyterian-St. Luke's Hospital Division of Surgery at the annual meeting of the Board of Trustees.

Dr. Julian joined the staff of St. Luke's Hospital in 1952. A graduate of the University of Chicago Medical School, he served his internship at St. Luke's Hospital in 1937 and his surgical residency at the University of Chicago Clinics, 1938-1942.

He has been a member of the medical staff executive committee at Presbyterian-St. Luke's since 1964. He is currently vice-president of the medical staff and a professor of surgery at the University of Illinois.

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: In ½ oz. and 1 oz. tubes
Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
Starting Dates — 1966

SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 16
SPECIALTY REVIEW COURSE IN MEDICINE, Part II, June 6
SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 15
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
SURGERY OF STOMACH & DUODENUM, One Week, June 6
GALLBLADDER SURGERY, Three Days, June 13
SURGERY OF HERNIA, Three Days, June 16
PROCTOSCOPY & VARICOSE VEINS, One Week, June 20
SURGERY OF TRAUMA, One Week, June 20
MANAGEMENT OF BURNS, Two Days, June 24 & 25
PRINCIPLES OF OPERATIVE SURGERY, Two Weeks, July 25
BASIC PRINCIPLES IN GENERAL SURGERY, Two Weeks, July 11
VAGINAL SURGERY, One Week, May 9, June 20
GYNECOLOGY, Two Weeks, June 6
GENERAL PRACTICE REVIEW, One Week, May 23
ADVANCED HEMATOLOGY, One Week, June 20
CLINICAL ENDOCRINOLOGY, One Week, June 13
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

TEACHING FACULTY
Attending Staff of
Cook County Hospital
Address: REGISTRAR, 707 South Wood Street
Chicago, Illinois 60612

"ALCOHOLISM is a DISEASE"

The Keeley Institute, Dwight, Illinois, specializes in the individual and group care of those having a drinking problem.

Our progressive, well-rounded program is conducted in an atmosphere of friendly cooperation under the direction of physicians and experienced personnel. We take female patients as well as male.

The alcoholic can be helped . . .

Why not write now for detailed information on our low cost, comprehensive services – or phone 815 584-3001.

The Keeley Institute is a member of the American Hospital Association – Licensed by the Dept. of Public Health, State of Illinois.

NEWS and ANNOUNCEMENTS

(continued)

Grants

The Center for Health Administration Studies at the University of Chicago has received a $1,117,065 grant from the Division of Community Health Services and the Division of Hospital and Medical Facilities. both parts of the Bureau of State Services of the U.S. Public Health Service.

The grant will be used to support a number of research projects investigating various aspects of medical care.

Included will be sociological, socio-psychological, economic, operational, and organizational studies.

Through these studies, research units at the Center hope to gain knowledge which will lead to improved hospital care, methods of financing medical care, physician practice, training of health administration personnel, and other related subjects.

Dr. Robert W. Carton, associate professor of medicine at the University of Illinois College of Medicine in Chicago, has received a $6,974 research grant from the National Foundation for a study aimed at uncovering possible breathing difficulties in patients with hereditary diseases of connective tissue.

The project is part of a nationwide March of Dimes research attack on birth defects.

Connective tissue, composed of fibers and a gluey cementing substance, is present

continued on page 626

Hospitalization For Emotionally Disturbed Patients

- MERCY HOSPITAL, Urbana, Ill., a not-for-profit general hospital, offers a Completely Modern, 30-bed Psychiatric Unit.
- The Unit is an evaluation & intensive treatment center, not intended for the care of the incurably mentally ill.
- It is equipped to offer more Intensive Care at Less Expense, Quickly Available Care, a Consultative Staff in Many Specialties, and has three Board-Qualified Psychiatrists on the Staff.
- All Physicians, staff and non-staff are invited to make psychiatric referrals.

For information concerning admission:

PSYCHIATRIC UNIT—MERCY HOSPITAL
1412 West Park Street, Urbana, Illinois
Area Code 217—Ph. 367-6621 Ex. 513

North Shore Hospital

On its doorstep, the restful vista of Lake Michigan

Care and Treatment of Emotional Disorders

NSH

Fully Accredited

225 Sheridan Rd. WINNETKA, ILLINOIS Hillcrest 6-0211

for information contact: Milton A. Dushkin, M.D.
MEDICAL DIRECTOR

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO OFFICE: Tam J. Hoehn and E. M. Breier, Representatives
55 East Washington Street, Room 1334, Chicago 60602 Telephone: 312-782-0990
MOUNT PROSPECT OFFICE: Theodore J. Pandak, Representative
709 Hackberry Lane (P. O. Box 105) Mount Prospect 60056 Telephone: 312-259-2774
ST. CHARLES OFFICE: Joseph C. Kunches, Representative
1220 Wing Avenue, St. Charles 60174 Telephone: 312-584-0920
SPRINGFIELD OFFICE: William J. Nattermann, Representative
1124 South Fifth Street, Springfield 62703 Telephone: 217-544-2251

ASSOCIATE

MEDICAL DIRECTOR

Chas. Pfizer & Co., Inc., seeks a physician who has had at least 2 years of private practice, for administrative responsibilities within one of its marketing divisions. For the individual desiring the challenge of a keenly competitive environment offering broad exposure to medicine and marketing, the intellectually stimulating advisory activities of this position provide manifold outlets for the application of technical training. Responsibilities include sales training, physicians' correspondence, and because of closeness to marketing situations, advice regarding the design and implementation of clinical evaluations, and the review of advertising from a medical standpoint. Naturally, professional affiliations and occasional travel are encouraged.

Individuals interested in an institutional endeavor involving responsibilities in medicine and administration should send a resume or letter listing qualifications to: MR. H. F. WHITE

CHAS. PFIZER & CO., INC.

Pfizer

235 EAST 42nd STREET, NEW YORK, NEW YORK 10017

An Equal Opportunity Employer

CLINICAL INVESTIGATORS

Unique opportunity for stimulating career in growing pharmaceutical company for physicians to design and monitor clinical trials of pharmaceuticals and biologics. Work also includes medical guidance for management.

DOW

Pediatric or internal medicine background; research or teaching experience helpful. Some travel. Salary dependent upon qualifications and experience.

Send detailed resume in full confidence to:
K. B. WEST

PITMAN-MOORE DIVISION
THE DOW
CHEMICAL COMPANY
P.O. BOX 1656
INDIANAPOLIS, INDIANA 46206

An equal opportunity employer

everywhere in the body and holds the organs and tissues together.

There are at least five well-recognized inherited disorders of connective tissue. Because it is distributed widely throughout the body, hereditary disorders of the tissue tend to cause multiple defects. Dr. Carton and associates will study breathing capacity of patients with three diseases in particular:

—Marfan's disease. Patients with this disease have a tall, thin build with disproportionately long legs, dislocation of the lens of the eye, defects in heart and blood vessels—particularly in the aorta. They often also suffer dislocation of hips and other joints and deformities of the breast bone and spine.

—Ehlers-Danlos syndrome. Disease is characterized by extremely elastic and abnormally fragile skin, freakish loose-jointedness, and small pseudo-tumors at pressure points such as heels, knees, and elbows. The "India rubber men" of the circus side-shows probably have this syndrome.

—Pseudoxanthoma elasticum. Victims have thickened, grooved skin, like Moroccan leather; blood streaks in the retina of the eye, sometimes with failing vision; and early arteriosclerotic changes in blood vessels which frequently rupture and cause dangerous hemorrhages.

The Illinois investigators will try to find out whether the mechanism of breathing is impaired in these patients, and if so, how severely. They also hope to learn whether the tissue of the lungs, diaphragm and other breathing muscles is also affected in these generalized disorders which cause connective tissue abnormalities in bone, skin and blood vessels.

It is widely believed that emphysema, a common disease of the lungs in elderly people, is fundamentally a defect in the connective tissue structure of the lung. Thus, studies of rare diseases may well help patients suffering from the more common disease of emphysema.

2 Approved Group Insurance Plans

for members of

THE ILLINOIS STATE MEDICAL SOCIETY

GROUP DISABILITY PLAN

TOTAL DISABILITY CAN BE COSTLY
Review Your Needs Today
Amounts Available up to
$250.00 Weekly

SPECIAL FEATURES

- SICKNESS BENEFITS TO AGE 65 PLAN
- THREE EXCELLENT PLANS TO CHOOSE FROM
- CONVERSION PLAN AVAILABLE AT AGE 70
- LOW RATES UNDER A TRUE GROUP POLICY

GROUP MAJOR MEDICAL PLAN

$15,000 MAXIMUM BENEFIT

Choice of 2 Deductibles

Dependent Coverage Available

Both IN and OUT of Hospital Expenses Included

Truly Catastrophic Protection

GROUP POLICY RATES

CALL OR WRITE

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance
ADMINISTRATORS

9933 LAWLER AVENUE SKOKIE, ILLINOIS PHONES 679-1000

Nervous
Geriatrics

Long Term and Short Term Care



Est. 1909

Mental
Custodial

Day Care and Mental Health Clinic

RESTHAVEN

This modernly equipped institution located in the beautiful Fox River Valley 35 miles west of Chicago, cooperates with physicians to the fullest extent.

It provides accommodations for 100 patients in single and double rooms. Resthaven accepts patients by referral and direct admission.

RESTHAVEN HOSPITAL, 600 VILLA ST., ELGIN, ILL.
Phone: SH 2-0327

OBITUARIES

Charles B. Alexander, California, formerly of Harvey, died April 10, aged 71. A graduate of Loyola University School of Medicine in 1917, he had served as medical examiner for the Civil Aeronautics administration, medical director of the Whiting corporation and surgical chairman of Ingalls Memorial hospital.

Frederic W. Brodie*, Geneva, died March 30, aged 39. A graduate of the University of Illinois College of Medicine in 1954, he was a staff member of Community Hospital.

Arnold U. Derman*, Chicago, died February 23, aged 60. In 1934 he was a graduate of Northwestern University Medical School.

Theodore F. Eichler*, West Dundee, died March 22, aged 74. A graduate of Chicago College of Medicine and Surgery in 1916, he had served as a health officer for many years.

Edward K. Ellis*, Murphysboro, died March 17, aged 74. He was a graduate of the National University of Arts and Sciences Medical Department in 1915 and a member of the Fifty Year Club of ISMS.

Sylvester F. Henry*, Effingham, died March 30, aged 85. A graduate of St. Louis University of Medicine in 1911, he specialized in ophthalmology.

Raymond Jezisik, Blue Island, died March 22, aged 65. In 1926 he was a graduate of Loyola University School of Medicine. He was a former staff member of St. Francis Hospital.

Harry Parker Knapp*, Oak Park, died March 21, aged 78. A graduate of the Hahnemann Medical College and Hospital in 1910, he was on the staff of West Suburban Hospital.

Cora A. Matthews*, California, formerly of Evanston, died February 26, aged 82. A graduate of the University of Illinois College of Medicine in 1916, she specialized in radiology. She was head of the x-ray department of Cook County Hospital for 12 years and then continued her private practice. Dr. Matthews was a member of many medical organizations.

William C. MacGregor, Chicago, originally from Canada, died April 9, aged 80. He was a graduate of Chicago College of Medicine and Surgery in 1915.

William S. McGinnis*, Alton, died April 6, aged 66. A graduate of St. Louis University School of Medicine in 1925, he was former medical staff president of St. Joseph's hospital.

Francis D. McNertney*, Bloomington, died April 4, aged 80. He was a graduate of Loyola University School of Medicine in 1916 and served as former president of Woodford County and North Central Illinois Medical Societies.

Julian A. Miller*, Chicago, died March 9, aged 39. A graduate of the School of Medicine of the University of Chicago in 1951, he specialized in psychiatry.

William J. Pollock*, Chicago, died April 1, aged 94. A graduate of Bennett Medical College in 1902, he retired in 1961. He was a member of the Fifty Year Club of ISMS.

Oswald H. Robertson, California, formerly of Chicago, died March 24, aged 79. A graduate of Howard Medical School in 1915, he was a pioneer in the establishment of blood banks. Dr. Robertson was a professor emeritus of medicine at the University of Chicago and won national acclaim for his many research projects.

Frank M. Sylvester*, Oak Park, died March 10, aged 82. In 1913 he was a graduate of the Chicago College of Medicine and Surgery.

Irvin Wiesman*, Granite City, died March 8, aged 55. A graduate of Washington University School of Medicine in 1935, he specialized in proctology. President-elect of the Madison County Medical Society, he was a staff member of St. Elizabeth's Hospital. He was a member of the International College of Surgeons and the International Academy and International Board of Proctology.

Emil R. Zidek*, Bloomingdale, died March 9, aged 56. He was a graduate of Chicago Medical School in 1935. During World War II he was awarded the Purple Heart and the Bronze Star.

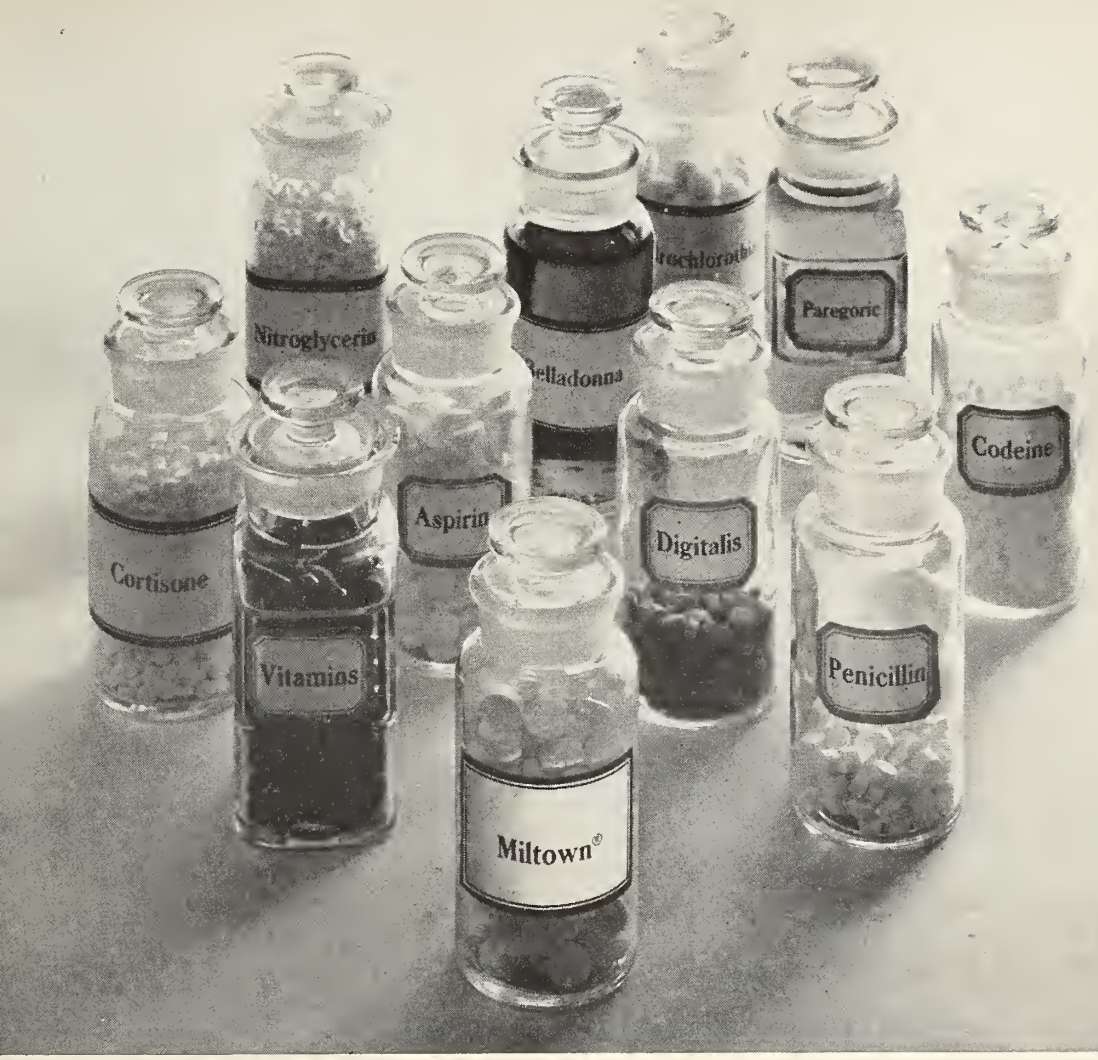
**Indicates member of Illinois State Medical Society.*



a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
Cranbury, N.J.

CM-5761

IMJ

Illinois Medical Journal

CONTENTS

volume 129, no. 6 *June, 1966*

MEDICAL PROGRESS

The Paraproteinemias, Part II
Robert S. Griffin, M.D. and Steven O. Schwartz, M.D., Chicago 663

CLINICAL ARTICLES

Basic Plastic Surgical Principles in Repair of Facial Lacerations
John W. Curtin, M.D., Chicago....657

A Personal Tribute to Dr. Percy Hopkins
James H. Hutton, M.D., Chicago....661

Is Attendance at a Private School Medical Treatment?
Lester Nathan, M.D. and Allan B. Muchin, Chicago....669

Malaria—A Continuing Problem
Martin S. Hirsch, M.D. and Robin D. Powell, M.D., Chicago 674

Smallpox Vaccinations Complications and Vaccinia Immune Globulin (VIG)
John T. McEnery, M.D., Chicago....678

Further Studies on Placebo Management of Skeletal Disease
C. B. Thrift, M.D. and E. F. Traut, M.D., Oak Park....683

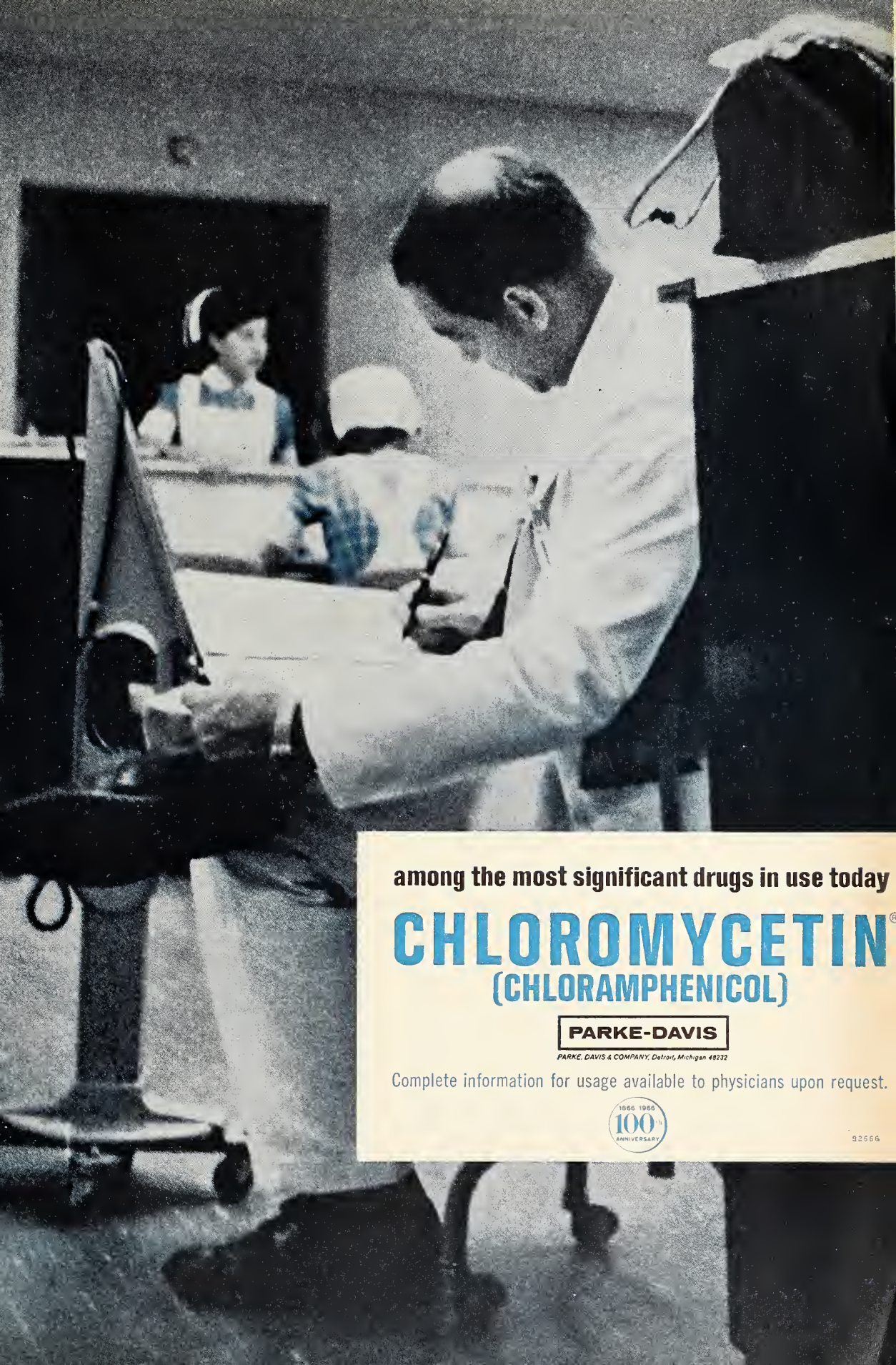
The View Box
Leon Love, M.D., Chicago....686

Summary and Highlights of the 1966 Convention....689

FEATURES

President's Page 644
Editorials 687
Cumulative Index to Volume 129....705
Dr. Sims in Action....711
Doctor's Library 718
IMAA Report 724
℞ Reviews and New Products....725
News and Announcements....726

Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Ill. 60601. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.50 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies available at cost of 75 cents. Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.
Copyright 1966, The Illinois State Medical Society.



among the most significant drugs in use today

CHLOROMYCETIN®
(CHLORAMPHENICOL)

PARKE-DAVIS

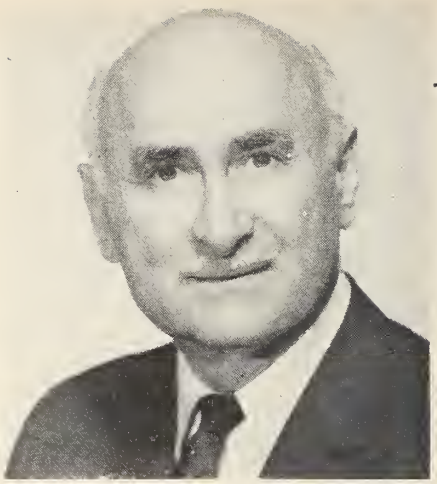
PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

Complete information for usage available to physicians upon request.

1866 1966 100th ANNIVERSARY

92566

The president's page



Caesar Portes, M.D.

OUR ATTENTION IS REQUESTED

I deem it a great honor and privilege to be chosen president of the Illinois State Medical Society. The personal pleasure I feel is tempered with humility and a measure of trepidation, knowing full well the awesome responsibilities that accompany this high office.

The Illinois State Medical Society, as one of the largest and strongest medical organizations in the country, is expected to display leadership, and it is this obligation that I propose to make my personal concern during the next twelve months.

To fulfill our role, it seems to me that these areas require our attention:

1. IMAGE OF THE DOCTOR: Public opinion toward our profession has declined because of our failure to respond to what is commonly referred to as house calls; our failure to inform the public of available appeal mechanisms such as grievance and ethical relations committees, and the increasing inaccessibility of doctors. We can overcome these "failures" and make the public aware that we have done this.

2. POSITIVE ACTION PROGRAM IN COMMUNICATIONS: We need to use all available communications media to answer criticisms of our profession and also give our members the necessary freedom to tell "our story."

3. COOPERATION WITH INSURANCE COMPANIES: We can increase the mutual understanding of doctors and private insurance companies through effective use of utilization and grievance committees.

4. COMMITTEES: The Society's committee system can be improved by encouraging broader participation, particularly by younger men, and providing for minority opinions.

5. EMERGENCY ROOMS: A study should be made of the total emergency room situation in Illinois hospitals, with a view toward developing a cooperative system to increase efficiency and coverage.

6. SHORTAGE OF DOCTORS: We need to take positive action to promote the prestige of the general practitioner and encourage greater numbers of medical students to become family physicians.

7. BOARD OF TRUSTEES: I believe we can limit the tenure of board members without losing the services of prominent physicians whose ability and mature judgment are so valuable to society activities.

8. POLITICS: I intend to support *bipartisan* political activities at all levels.

9. SUPPORTING THE AMA: We must continue to support our mother organization, eliminate splinter groups, and encourage all members to participate in organized medical affairs from the county level up.

10. PLANNING FOR THE FUTURE: We must provide for future leadership in our profession by developing tomorrow's leaders today.

It is a pleasure to have the opportunity each month to discuss with you, through the pages of our journal, some of the problems—and, I hope, the achievements—which we as physicians in Illinois should be aware.

IMJ

Illinois Medical Journal

volume 129, number 6 June, 1966

BASIC PLASTIC SURGICAL PRINCIPLES IN REPAIR OF FACIAL LACERATIONS

John W. Curtin, M.D./chicago

THE PHYSICIAN ADMINISTERING the initial treatment for craniofacial trauma has indeed a great responsibility. Depending on what is done or more important what is not done, his treatment determines to a large extent the final outcome.

The face, unfortunately, is the center of attention in social interaction, the dominant part of the body image and the part most revealing of the personality traits of the individual. Even after the physical scars have diminished the psychological imprint may leave its mark on the young man or woman for a lifetime. Physical and psychological rehabilitation of the facially disfigured is a long, tedious and oftentimes impossible process.

An evaluation of the entire patient must be made in order to establish proper priority of management. This is particularly important when dealing with the patient with multiple wounds of the body.

An adequate airway must always be given first consideration; not only should it be established but it must be maintained. This may necessitate an emergency tracheotomy when dealing with extensive facial injuries. Hemorrhage has to be controlled and shock corrected. Reduction of facial fractures may be postponed for several days (up to 2 weeks) until the patient's general condition will permit surgical correction.

Adequate anesthesia must always be provided. In dealing with extensive wounds, an uncooperative patient, or with children, general endotrachial anesthesia is preferable.

Wound Preparation

Prior to closure of soft tissue wounds, they must be properly prepared. They are first cleansed well under surgical conditions by washing thoroughly with white soap and sterile water, using sterile cotton —never gauze. Gauze is rough and may produce mechanical abrasion of the skin. When present, hair is shaved away from

Clinical Professor of Surgery and Head of Division of Plastic Surgery, Department of Surgery, University of Illinois College of Medicine.

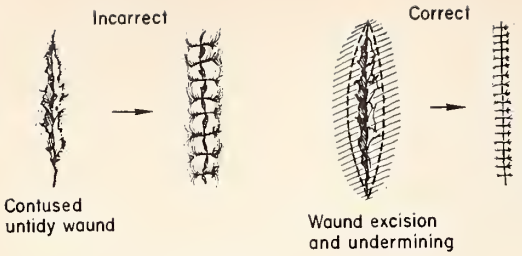
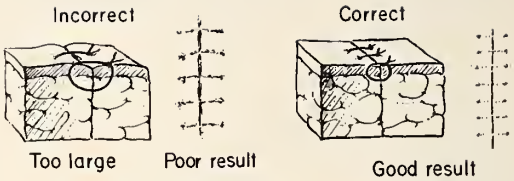


Fig. I. Skin Laceration



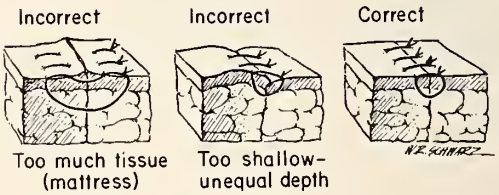


Fig. 2. Suture technique

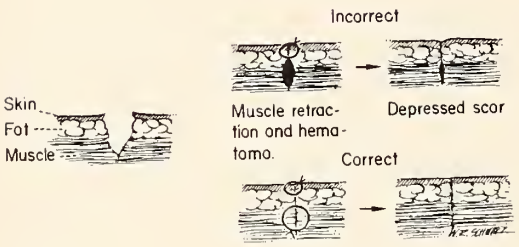


Fig. 3. Muscle Injury

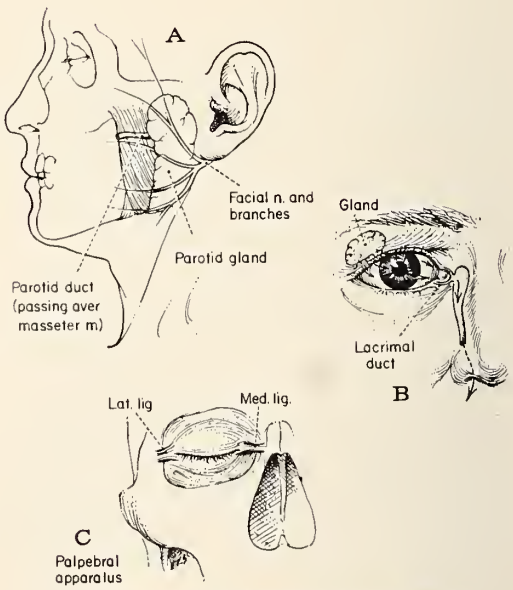


Fig. 4. Structures Requiring Primary Repair

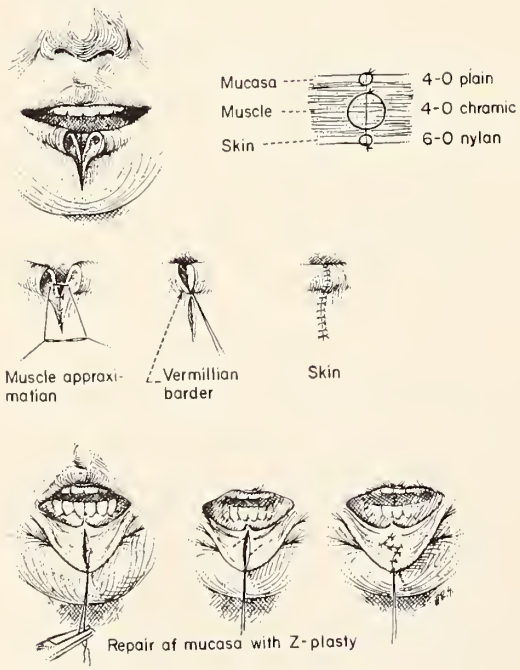


Fig. 5. Through and through lip laceration

the wound. Eyebrows are never shaved. It is imperative that eyebrows be preserved since they provide accurate anatomical landmarks around which the wounds may be approximated. Failure to observe this point may result in subsequent eyebrow irregularity. The wound is irrigated with copious quantities of warm sterile physiologic saline solution. The above procedures must be with the aid of adequate anesthesia, either local or general as indicated.

Inground Foreign Material

After cleansing, the wound is inspected carefully with a magnifying lens if necessary. Strict attention is paid to the presence of any foreign material. This must be removed at once because such foreign material becomes "fixed" into the tissue edges of lacerations or into abrasions. Failure to remove it will leave permanent pigmentation in the skin, commonly referred to as an "accidental tattoo." If the material is grease or paint, it can ordinarily be dissolved with ether. If the foreign material is street dirt or gun powder, vigorous scrubbing with a stiff brush is carried out. If the material is deep or difficult to dislodge, the use of a motor driven wire brush may be helpful. In case the discoloration is limited to the wound edges only, it may be better to debride these areas with a sharp straight edged scalpel. Anesthesia of the area to be cleansed or abraded is essential.

After the abraded wound has been treated, it is dressed by covering with sterile fine nylon silk and a gauze dressing applied under moderate pressure.

Lacerated Wounds

After preparation one must inspect carefully the edges of all lacerated wounds for evidence of contusion or small jagged edges that might lead to necrosis. Any segments that are doubtful of survival should be excised with care taken to cut at right angles to the plane of skin and out to viable, bleeding normal tissue (Figure 1). Atraumatic handling of the tissues with fine and delicate instruments will minimize the chances of poor results. Complete hemostasis has to be achieved and the wound closed in layers without tension. This may necessitate undermining of skin and subcutaneous tissues adjacent to the wound edges.

Interrupted sutures of 5-0 or 6-0 monofilament nylon are used and placed approximately 1/8 inch apart to obtain accurate coaptation of the everted skin edges (Figure 2). Tight sutures cause tissue necrosis with gross delay in wound healing and produce "railroad ties" across an otherwise satisfactory scar. Thin skin heals rapidly so that eyelid sutures can be removed in two to three days. Thicker skin that overlays heavy musculature is slow to heal and suture removal should await longer periods of time. Following suture removal support of the wound with strips of colloidinized gauze for approximately three weeks will minimize separation of wound edges.

Deep Wounds

A careful inspection must be made of all deep lacerations. Divided muscles are reapproximated with interrupted sutures of 4-0 chromic catgut (Figure 3). Where muscle is severed, a two layered closure is important, otherwise the muscle will retract with hematoma filling the gap, eventually organizing to produce contracting scar tissue and hence a depressed skin scar. The divided ends of the parotid duct or the facial nerve must be identified and anastomosed. A thin polyethylene catheter should be threaded through the bisected parotid or lacrimal duct and anastomosed with a few interrupted sutures of 6-0 silk (Figure 4). Surgical reattachment of severed palpebral ligaments also requires primary repair.

When confronted with through and through lacerations of the lips or cheeks, surgical closure must be extremely accurate particularly at the vermilion border of the lip (Figure 5). In anticipation of considerable edema it is best not to place any sutures in the mucosal layer or only a few strategic catgut sutures where noticeable separations are present.

Repair of eyelid lacerations is best carried out in the operating room where proper instruments, suture material and assistants are available (Figure 6). A single straight line repair may result in lid contracture. Z-plasty procedures particularly at the lid margins are mandatory.

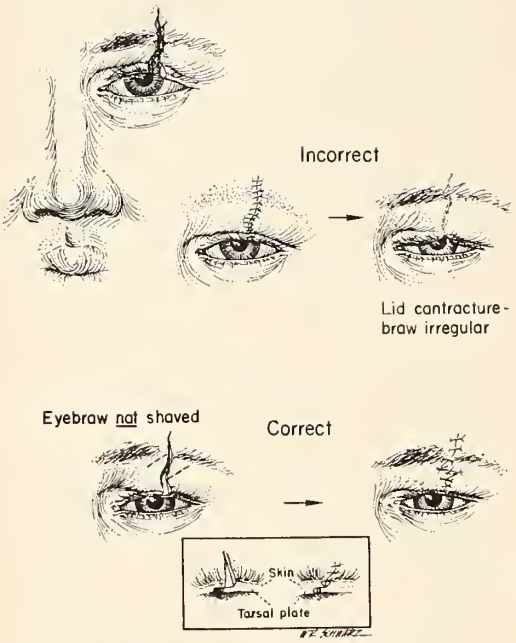
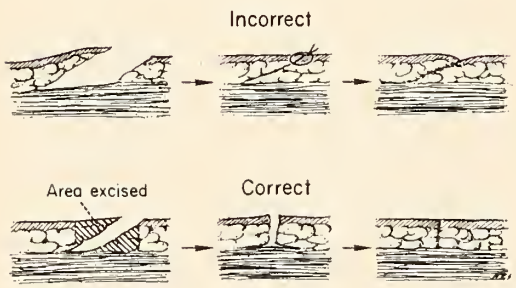


Fig. 6. Eyelid Lacerations



Suture Materials:

Muscle	4-0 Chromic catgut
Subcuticular ligatures	4-0 Plain catgut
Skin	5-0 or 6-0 Nylon (silk)

Fig. 7. Slicing Wound

If a large segment of skin has been avulsed, it should always be looked for at the scene of the accident. Unless it is hopelessly contused or mangled, it can usually be saved and utilized with a better final result than by substituting a skin graft from some other site. Even though grossly dirty, it can be prepared in the same way the wound was cleansed. Any underlying fat is trimmed off and the skin reapplied to its original bed in the form of a free full-thickness skin graft.

Skin flaps that have been partially avulsed are always precarious in their behavior. Invariably they have a better arterial supply than they do a venous return. This predisposes to venous congestion and moist gangrene. Flaps of this type can frequently be saved by deliberately dividing the remaining pedicle, removing the underlying attached subcutaneous fat, and then reapplying the skin as a free full-thickness graft.

The more common slicing wound (Figure 7) with bevelled edges will often heal with contraction along the oblique tract of fibrous tissue, resulting in a rolled wound margin. This will be even more apparent in the "trap door" wound where the circular scar also contracts causing further pouting of the wound margin.

Avulsions of large organs such as an entire nose or ear are serious catastrophes. Because of their large mass, they cannot be expected to grow if reapplied. However, in the case of an avulsed ear, one should remove the overlying skin and salvage the underlying auricular cartilage.

Summary and Conclusions

1. In the treatment of facial trauma an evaluation of the entire patient must be made in order to establish proper priority of management.

2. An adequate airway must be established and shock corrected before repair of the facial lacerations.

3. Adequate anesthesia (local or general) is mandatory for cleansing of and proper inspection of the wound and reapproximation of the wound in layers.

4. The use of fine instruments and atraumatic technique will assure a good final result in an anatomical area where a rich blood supply is our greatest ally.



A PERSONAL TRIBUTE TO DR. PERCY E. HOPKINS

James H. Hutton, M.D.

Percy graduated in 1916 and became a member of the Chicago Medical Society in 1919. He became President of its Englewood Branch and a member of the Chicago Medical Society Council in 1930. He was active in this for many years and was chairman of many active committees (Grievance, Legislative, Press Relations, Medico-Legal, Resolutions, Representative to Chicago Hospital Council, Special Committee for Doctors' Emergency Service and the Committee on Committees).

He became a member of the Illinois State Medical Society Council in 1936. He was also a member and chairman of many committees in the State Society. In 1959 he was a member of the committee which brought about the reorganization of the Illinois State Medical Society.

And yet in a way Percy's rise in medical organization has been little short of meteoric. When the State Society met in Peoria in 1941, Percy and "G. E." (the late Dr. G. E. Johnson—he and Percy were inseparable companions) and their wives came to Peoria to the meeting. Someone said to him that it was nice to see a man of his stature so interested in medical society work. His reply was that he wasn't so much interested in that stuff; he simply came down to pay his respects to the retiring president. But nine years later he was the retiring president and now 25 years later he is retiring from the top-flight post in American Medicine, a post he has filled with distinction and, I am sure, to the satisfaction of most of the membership.

He served as president and chief of staff of Evangelical Hospital; was the primary mover in teaching the practice of good medicine; was primary organizer and first president of the staff of the new Christ Community Hospital.

There is, oeeasionally, a man who inspires so mueh affection in his eompanions that he is always ealled by his first name. This is true of Perey. Almost nobody refers to him as "Doetor Hopkins." He has had a distinguished eareer. He has lived with his lovely wife Leonora for many years. He was in Europe in the First World War. He has two sons, Bob and Bill. Bob was seriously wounded in the Seeond World War while earrying baek a message under gunfire. For this he was deeorated and given the Purple Heart. Bill distinguished himself in the Korean War and was awarded the Soldier's Medal for reseuing a pilot from a burning helieopter. He is a eompetent surgeon in his own right and has two ehildren, "Little Bill," 14 and Barbara, 12.

Perey is also a good eook, a eompetent judge of wine and some other liquors. He is an expert fisherman and hunter and used to play a good game of golf.

If Perey were to look baek over his life he would, I believe, have a great deal to be proud of and little, if anything, to regret. He appears to be one of those fortunate men who is able to make the right deeision at the right time. The State Soeiety honors itself in honoring him.

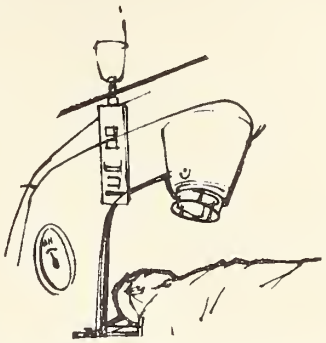
Editor's Note: Dr. Percy E. Hopkins retires as a member of the American Medical Association's Board of Trustees, a post he has held since 1959. He served as Chairman of the Board for the last two years. Prior to that service, he represented Illinois for eight years as a member of the AMA House of Delegates.

Dr. Hopkins was a member of the Board of Trustees of the Illinois State Medical Society from 1936 to 1950, serving as its president in 1949. He was chairman of its Committee on Medical Service and Public Relations. He has also served as chairman of the Advisory Committee to the Veterans Administration, the Committee on Voluntary Prepayment Plans for Medical and Surgical Care, the Committee on Medical Service and Public Relations and the Committee on Military Affairs (which provided for the care of dependents of members of the Armed Services at home).

ANIMAL CARE BILL

The House Agrieulture Committee ordered favorably reported, with amendments, H.R. 13881 whieh would regulate the transportation, sale and handling of animals in researeh and experimentation. Among other ehanges, the bill has been limited to apply only to dogs and eats, and requires the lieensing by the Seeretary of Agrieulture of researeh faeilities that use dogs and eats for experimental purposes as well as dealers in these animals. The bill would authorize the Secretary to preseribe humane standards for the transportation and handling of animals destined for the research laboratory. The Seeretary eould also require the humane marking and tagging of dogs and eats handled by the researeh dealers so as to eurb the stealing of family pets. The bill has been sent to the Rules Committee whieh is expected to take prompt aetion on it. *AMA Legislative Roundup, March 25, 1966.*

Medical Progress



Harvey Kravitz, M.D./progress editor

THE PARAPROTEINEMIAS

PART II

Robert S. Griffin, M.D. and Steven O. Schwartz, M.D.

Antibody Activity

Following the identification of the three major types of immunoglobulins, it has become obvious that the bulk of all antibody activity resides in the $gamma_G$ fraction of serum proteins.[48] However, antibody activity has also been demonstrated in $gamma_M$[49] and $gamma_A$[50] globulin fractions. Heterophile antibody, typhoid O antibody, and cold agglutinins are macroglobulins. Only a few $gamma_A$ antibodies have been identified, and these are thought to include the antibodies to diphtheria and brucella abortus. Some antibodies, for example isoagglutinins and insulin antibodies, have been identified in more than one immunoglobulin fraction. Evidence is at hand that early in immunization antibody activity resides primarily in the $gamma_M$ fraction with a subsequent change to $gamma_G$ globulin.[51, 52] This change begins one to two weeks after the initiation of immunization and is complete after four to eight weeks. A cut-off mechanism may be operative in the production of $gamma_M$ and $gamma_G$ globulins. It has been shown that the production of $gamma_M$ antibodies, taking place early in immunization, can be aborted by supplying exogenous end stage $gamma_G$ globulin.[53]

It seems a paradox that infection should be the most frequent cause of death in the paraproteinemias — diseases characterized by excessive amounts of immunoglobulins. However, these paraproteins, with a few exceptions, are devoid of any known antibody activity, and are accompanied, in most cases, by decreased levels of normal gamma globulin. Moreover, even patients with normal levels of normal gamma globulins exhibit impaired production of appropriate antibody after antigen administration. The increased susceptibility to infection in such patients correlates well with the degree of impairment of antibody responsiveness. However, a correlation cannot be made between the degree of susceptibility to in-

Department of Hematology, Hektoen Institute for Medical Research of the Cook County Hospital, Northwestern University Medical School and University of Illinois College of Medicine, Chicago.

fection and the type of paraprotein present or the depth of decrease in normal gamma globulins.[54]

Reasons have not been advanced for the decreased levels of normal gamma globulins and poor production of antibodies. That this does not simply represent overgrowth of the marrow by one particular clone of cells with crowding out of other clones is evidenced by the fact that the degree of decrease in normal gamma globulins does not correlate well with the extent of disease as measured by degree of marrow replacement. A better explanation might be that genetically determined hypogammaglobulinemia precedes and accounts for the development of the paraproteinemia.

Hypogammaglobulinemia may be the consequence of increased metabolism. An increase in the catabolism of normal $gamma_G$ globulins has been shown in patients with $gamma_G$ paraproteinemia, but interestingly, the survival times of normal $gamma_G$ globulins in patients having Bence Jones proteinuria or serum peaks of $gamma_A$ or $gamma_M$ globulins have been shown to be normal or increased.[54]

Because infection is the major cause of death in the leukemias and lymphomas as well as in the paraproteinemias, the tendency is to think that all these diseases share a causative common denominator. It is true that certain lymphomas, primarily chronic lymphocytic leukemia and lymphosarcoma, are frequently accompanied by a hypogammaglobulinemia or impaired antibody responsiveness.[55, 56] However, hypogammaglobulinemia does not occur during the natural course of other leukemias, and is not observed in Hodgkin's disease, in contrast to the other lymphomas.[57] It is not generally recognized that anergy is present in about 50% of patients with Hodgkin's disease.[58, 59] This anergy is commonly present early in the disease and is not a reflection of end stage disease or of the effect of chemotherapy. Associated with this anergy is a significant increase in the incidence of tuberculosis and fungous infections.[60] As late as 1959 it was said that at autopsy 5% of all patients with Hodgkin's disease were found to have active tuberculosis.[61] In all these diseases susceptibility to infection has been increased as a consequence of modern therapy. The use of adrenal steroid hormones and immunosuppressive agents has not only increased the incidence of pyogenic and tuberculous infections, but has also produced a change in the pattern of complicating fungous infections.[62, 63, 64] Infections with aspergilla, candida, and mucomycosis have greatly increased, and in some series are found in about half of the patients dying with diseases of the reticuloendothelial system. Cryptococcosis and histoplasmosis have frequently been associated with diseases of the reticuloendothelial system. However, their incidence has not changed significently in recent years. Not all fungi are opportunists: infections with actinomycosis, blastomycosis, coccidiomycosis, maduromycosis, nocardiosis, and sporotrichosis are no more frequent in patients with diseases of the reticuloendothelial system than in the general population.

Genetic Determination of Serum Proteins

In recent years the existence of genetically determined differences in serum proteins has become apparent. This was first demonstrated for haptoglobins and transferrin using electrophoretic mobilities. Genetically determined differences in human gamma globulins are also demonstrable, but the necessary techniques employed are extremely cumbersome. The information obtained has been the by-product of investigations into the properties of rheumatoid factors. Rheumatoid factor has the ability to react with gamma globulins from a variety of species. Its reaction with rabbit gamma globulin forms the basis of the sheep cell agglutination test, and its reaction with human gamma globulin is used in the latex agglutination test. Grubb and Laurel,[65] in 1956, showed that certain rheumatoid sera would react with incomplete human Rh antibody to produce agglutination of Rh positive cells. They showed that this agglutination could be inhibited by sera from some patients, but not from others; that the factors responsible for the inhibition or lack of inhibition resided in the gamma globulin fractions of the sera, and that these factors were genetically determined. Considering the specificities of different rheumatoid factors, Fudenberg and Kunkel[66] have postulated the existence of at least seven different gamma globulin groups. Six of these have already been identified:[67, 68]

Gm(a), Gm(b), Gm(x), Gm(r), InV(a), and InV(b). The Gm in this terminology represents an abbreviation for gamma globulin, and the InV is a combination of In for inhibitor and V, the initial of the patient from whom the original test serum was obtained. The inheritance of these factors as known at present is: one pair of chromosomes bears the genes determining the allelic factor Gm(a) and Gm(b). Gm(x) and Gm(r) may be present or absent in Gm(a) individuals, but are never present in the absence of Gm(a). The allelic factors InV(a) and InV(b) are determined by other genes, probably on another chromosome at a locus distinct from the Gm locus. An interesting correlation can be made between these genetic factors and the sub-units of the immunoglobulins. Gm factors are restricted to the $gamma_G$ fraction of the serum globulins and are never present in $gamma_A$, or $gamma_M$ globulins. On the other hand, InV factors may be present in $gamma_A$, $gamma_M$, and Bence Jones protein, as well as $gamma_G$ globulins. The distribution of these factors would support the theory that the S fragments, or common antigenic determinants of the immunoglobulins, are controlled by one genetic locus (InV), and that the F fragment, or the specific antigenic determinant for each class of immunoglobulin (in this case, $gamma_G$), is controlled by a separate genetic locus. The test system employed has excluded the possible detection of antigens on the class specific parts of $gamma_A$ and $gamma_M$ globulins, but they are referred to theoretically as Gm(3) and Gm(4) respectively. Fudenberg has suggested that this information may offer a new approach to the study of aberrations of gamma globulins in such diseases as agammaglobulinemia.[67]

Several types of agammaglobulinemia have been described. In the classical form of sex-linked congenital agammaglobulinemia, all three major immunoglobulins are decreased. This type of agammaglobulinemia could well be the result of a mutation at the common InV locus with resulting suppression of formation of all three major immunoglobulins. With the same reasoning, isolated decrease in $gamma_G$ globulin might be due to a mutation of the Gm gene, with suppression of synthesis of that immunologic fragment specific for $gamma_G$ globulin. Affected females with double doses of the InV mutant would die in utero. Other combinations could involve the specific determinants of $gamma_A$ and $gamma_M$ globulins with resulting decrease in any two of the three immunoglobulins.

Renal Lesions in the Paraproteinemias

Next to infection, the commonest cause of death in cases of myeloma is renal failure, and as pointed out by Sanchez,[69] the renal syndromes are various. The term *myeloma kidney* was coined by Oliver[70] in 1945 to describe a pathognomonic appearance of the kidney. Bell,[71] in 1933, had postulated that the major pathologic lesion in the kidney in myeloma was produced by plugging of the tubules with Bence Jones protein. By micro-dissection technique, Oliver confirmed the presence of laminated proteinacious casts typically involving almost the entire nephron, including the proximal convoluted tubules, surrounded by multinucleated giant cells. The tubules showed proximal distention and secondary atrophy of the glomeruli. The casts were observed only in patients with Bence Jones proteinuria. However, the presence of Bence Jones proteinuria does not necessarily mean that myeloma kidney will develop. This fact seems to be related more to specific properties of different Bence Jones proteins than to the duration of disease or quantity of protein in the urine. It is more than likely that in addition to the mechanical plugging effect, Bence Jones protein also has a direct cytotoxic effect on cells of the kidney tubules. Such a direct effect on cells in the proximal convoluted tubules may explain the curious occurrence of the adult Fanconi syndrome in patients with myeloma.[72, 73] Acute and chronic pyelonephritis are common, and at autopsy about 50% of patients dead of myeloma have had significant urinary tract infection. Obviously this infection is related in large part to the disturbance of the immune mechanism, but is due also to the effects of hypercalcuria.

Amyloid

The most interesting associated renal lesion, present in about 10 to 15% of patients with myeloma, is para-amyloid (primary amyloid). The term amyloid, coined

by Virchow[74] in 1855 to describe a substance observed in a patient with chronic sepsis by Rokitansky[75] in 1842, refers to a hyaline-like material of glycoprotein nature which is regularly stained by iodine, congo red, and certain metachromatic dyes. This is the type of amyloid characteristically associated with a variety of chronic inflammatory diseases, familial Mediterranean fever, occasionally Hodgkin's disease, and rarely hypernephroma, and is called *secondary amyloid*. It typically involves parenchymatous tissues with infiltration and enlargement of liver, spleen, kidneys, and adrenals. The term *para-amyloid* was coined later to describe similar hyaline-like material with less constant tinctorial behavior observed in patients such as those reported by Wild[76] in 1886 without evidence of the diseases commonly associated with secondary amyloidosis. Lubarsch,[77] in 1929, pointed out that this type of amyloid characteristically involves mesenchymal tissues, with infiltration primarily of the tongue and heart. In recent years, it has become obvious that there may be, and often is, a great deal of overlapping between these two types of amyloid, so much so that many pathologists doubt a significant difference between the two. However, continuing the classification seems of some value.

Amyloid With Multiple Myeloma

It has been recognized that the amyloid in patients with multiple myeloma usually has the staining properties and distribution pattern of the material in patients with idiopathic and familial primary amyloidosis.[78] This led Apitz,[79] in 1940, to search for (and find) evidence of plasma cell dyscrasias in patients previously diagnosed as having primary amyloidosis. He concluded that most, if not all, cases of idiopathic primary amyloidosis represent occult or overt myeloma. Interestingly, despite the frequent occurrence of primary amyloidosis in patients with multiple myeloma, there are only two references to the occurrence of para-amyloid in association with macroglobulinemia.[80, 81]

Secondary amyloid classically involves the kidney. Glomerular lesions are frequent, and the nephrotic syndrome is common. Primary amyloid, of the idiopathic or familial types, may involve the kidney as part of its general involvement of small and medium sized arterioles. It usually does not involve the glomerulus, but on occasion may, and when it does, it may produce a nephrotic syndrome. Repeated published references are made to myeloma and myeloma with para-amyloid as causes of the nephrotic syndrome. Most specific references[82] in the recent past have been to an article containing few clinical details, written by Squire,[83] in 1956. Snapper says that it never occurs.[84] Osserman reports a patient with myeloma protein and Bence Jones proteinuria who had the nephrotic syndrome.[85] The case was not classical, however, for bone lesions were not demonstrable and a chronic pyelonephritis was present which could have provoked formation of the amyloid. That the nephrotic syndrome ever occurs with myeloma is somewhat doubtful. Certainly, it never occurs in myeloma without amyloid.

2 Sites of Amyloid Deposition

Discounting generalizations made about gross differences in distribution of the various types of amyloid, the disparity among incidences of the nephrotic syndrome points up some apparent specific differences in the involvement of blood vessels. Missmahl,[86] in 1959, using polarized light microscopy, defined two sites of amyloid deposition. He called these *peri-reticular* when the initial deposition was subendothelial with subsequent spread to the media, and *peri-collagen* when the initial deposition was in the adventitia with subsequent spread to the media. In many further studies by Blum, Gafni, Heller, and Sohar[87, 88] of patients with familial Mediterranean fever as well as primary amyloidosis and other types of secondary amyloidosis, a definite correlation has been asserted between the type of distribution and the type of disease. According to those investigators, patients with secondary amyloidosis always have a peri-reticular distribution of the amyloid (which would include the glomeruli). On the other hand, patients with primary amyloidosis, including those patients with myeloma, always have a peri-collagen distribution (which would spare the glomeruli).

Regardless of any fine differences in the sites of deposition of the various types of amyloid in or about blood vessels, there

can be no question but that amyloid, regardless of type, is deposited in definite relation to vessels. This was in part the reason for Osserman's suggesting that amyloid, regardless of type, is produced by the passage of small Bence Jones-like serum globulins through the vessel walls with subsequent combination with certain tissue polysaccharides to form insoluble complexes.[85, 89] This might be true. As a rule, para-amyloid is not seen in myeloma in the absence of Bence Jones protein. The true composition of amyloid is not much clearer now than it was when Virchow mistakenly called it starch-like (amyloid). Because of its insolubility, adequate chemical characterization has not been possible. Some indirect disclosures seem to have significance. Vasquez has shown, by immunofluorescent techniques, the presence in amyloid of constituents related to gamma globulin.[90] On electron microscopy, Gueft[91] has shown that amyloid is not amorphous, but actually is composed of tubular or double stranded structures. Interestingly, this ultra structure is the same for all types of amyloids. However, Benditt[92] has presented suggestive evidence of different chemical structures for primary and secondary amyloid. Using urea, he extracted substances from amyloid and showed that material thus extracted from primary-type amyloid differed from that extracted from secondary-type amyloid in electrophoretic characteristics.

Causes of Deposition

If little is known about the composition of amyloid, even less is known about the causes of its deposition. The most attractive thought in recent years has been that amyloid represents complexing of small serum proteins with tissue polysaccharides. Magnus-Levy,[93] in 1931, was the first to suggest such a phenomenon when he pointed out the frequent simultaneous presence of para-amyloid and Bence Jones proteinuria in patients with multiple myeloma. The Bence Jones protein, being small enough to pass the glomerulus, is also small enough to diffuse through the walls of arterioles throughout the body to unite with specific tissue polysaccharides, which in this case would assume the part of the antigen. This theory of antigen-antibody reaction is supported by the utilization of the complement.[94] Osserman[85] goes a step further by postulating that in all cases of amyloid a similar mechanism is operative. The only difference, he thinks, is that in secondary amyloidosis the small serum antibodies are produced by the plasma cells present as the result of chronic stimulation of the reticulo-endothelial system rather than plasma cell neoplasia. To support this idea, he has been able to demonstrate Bence Jones-like proteins in sera of a significant number of patients with secondary amyloidosis. Indeed, it is often difficult to distinguish such plasma cell dyscrasia from true neoplasia, except for the presence of bone destruction in true neoplasia. There is evidence in animals that dyscrasia may actually become neoplasia.

Plasmacytomas

In 1959, Merwin and Algire[95] were able to produce plasmacytomas in BALB/c mice by implanting Millipore diffusion chambers intraperitoneally. It has since been shown that other forms of chronic mild irritants (notably mineral oil) injected intraperitoneally also produce plasmacytomas.[96] The unusual thing about such plasmacytomas, however, is that once produced, they become transplantable and thence behave as neoplasms.[97]

Amyloid may be produced not only as a consequence of plasma cell neoplasia or induced plasma cell dyscrasia, but also as part of two genetically determined diseases: familial primary amyloidosis and familial Mediterranean fever. Although protein studies have not been extensively performed in patients with these diseases, it has been observed that the alpha-2 globulins are often increased in patients with familial primary amyloidosis. One seemingly specific finding in such patients has been vitreous opacities composed of amyloid.

Amyloid, with secondary-type distribution, was first observed in patients with familial Mediterranean fever by Heller,[98] in 1955. Sohar,[99] in 1961, showed familial Mediterranean fever to be a genetically determined disease (non-Ashkenazi Jews and gentile Armenians) transmitted as a complete autosomal recessive gene. Forty percent of patients with this disease have amyloidosis. Curiously, however, the amyloid is independent of the attacks of fa-

milial Mediterranean fever, often being absent in patients with severe long-standing disease, and often present in patients with minimal attacks. This led Blum[88] and Heller[100] to postulate that amyloid is not secondary to the disease itself, but rather represents another genetically determined character of the disease. This has been further supported by family studies showing frequent occurrence of amyloidosis without familial Mediterranean fever in relatives of patients with familial Mediterranean fever. Such patients represent a field for further investigation. Detailed related protein studies have not yet been reported. And Marcus Aurelius knew that "this too will be swept away," for as Edmund Burke was able to observe of government in 1777: "Nothing in progression can rest on its original plan. We might as well think of rocking a grown man in the cradle of an infant."

References available upon request to the Editor.

WITHIN 5 YEARS - 14 NEW MEDICAL SCHOOLS

Fourteen new medical schools are expected to be in operation in the United States by 1970.

These will bring to 101 the nation's total of schools of medicine, and mark an "era of major expansion" in American medical education, said a recent issue of the *Journal of the American Medical Association.*

"Of obvious and immediate importance is the fact that 800 to 1,000 new positions will be available to qualified medical applicants," the Journal said. "This will help to meet the urgent national need for more physicians."

The new medical schools are but one of the indicators that American medical education is expanding.

The 65th annual report on medical education by the AMA's Council on Education contains data which mark continuing gains in graduate medical education, continuing medical education, educational programs in areas allied to medicine, and programs of government agencies pertinent to medical education.

All of the new medical schools will introduce modifications of the standard medical curriculum. This should lead to "some very interesting experiments in medical education," the Journal said.

The new schools also will be competing for faculty with existing schools.

"This will certainly aggravate an existing manpower problem, but it will also open up new opportunities for leadership to young, vigorous medical scientists."

Eight of the 14 schools being planned will provide full four-year programs leading to the M.D. degree. The other six are envisioned as two-year schools of the basic medical sciences.

"However, three or four of the latter may well progress directly to four-year programs after they have become firmly established," the Journal said.

The four-year schools: The University of Arizona College of Medicine, Tucson; University of California, San Diego, School of Medicine; University of Connecticut School of Medicine, Farmington; Milton S. Hershey Center, Pennsylvania State University, Hershey; Mt. Sinai School of Medicine, New York City; South Texas Medical School, University of Texas, San Antonio; University of Massachusetts, and Toledo State College of Medicine, Toledo, Ohio.

The two-year schools: Brown University Program in Medical Science, Providence, R.I.; University of Hawaii Medical School, Honolulu; Michigan State University College of Human Medicine, East Lansing; Rutgers University Medical School, New Brunswick, N.J.; University of California at Davis, and the University of New Mexico School of Medicine, Albuquerque.

The University of New Mexico accepted its first class in September 1964. As a developing two-year school, it becomes eligible for full accreditation when its first class nears the end of the sophomore year.

IS ATTENDANCE AT A PRIVATE SCHOOL MEDICAL TREATMENT?

A DOCTOR'S VIEWPOINT

Lester Nathan, M.D./chicago

IN RECENT YEARS the emotionally disturbed and mentally handicapped child has been receiving the attention long overdue in the fields of education and medicine. The true relationship of these two disciplines is so intertwined as to make separation impossible. The physician has been challenged to support with medical interpretation and medical foundation all of the existing material in his files to separate and justify medical premises for mental and emotional conditions.

Specific "treatments," may now be accepted in the form of special schooling interviews or curricula instead of the usual pills or tranquilizers. It should be further pointed out that many connections between known organic diseases and emotional problems cannot be easily or readily definable, but are expressed on a "clinical basis." A physician's clinical impression oftentimes lacks the overt measurable objectivity to satisfy a court of law, but nevertheless does exist, and hence is frequently misinterpreted or misunderstood, either

Associate in Pediatrics, Northwestern University Medical School; Associate Attending, Cook County Hospital; Supervising Public Health Officer, Chicago Board of Health.

A LAWYER'S VIEWPOINT

Allan B. Muchin/chicago

PARENTS OF EMOTIONALLY disturbed and mentally retarded children are burdened with heavy medical expenses that others, fortunate enough to have "normal" children, do not incur. Despite this hardship, a recent Tax Court decision, *Grant Atkinson, Jr.* 44 TC #3(1965) held that the cost of sending an emotionally disturbed child to a private school that does not have medical facilities is not a deductible medical expense even though a doctor recommended attendance at such a school. However, a Tax Court memorandum decision, *Rolland I. Olson*, TC Memo. 1964-325, filed four months prior to *Atkinson*, allowed a similar deduction for a mentally retarded child. Although the author represented the Commissioner in the *Atkinson* case, he feels that case could have been, and should have been, decided for the taxpayer.

It seems that today's parents are more conscious of the problems their children may have and are more likely to seek professional guidance than were previous generations. Many children who used to have

Attorney in the firm of Altman, Kurlander & Weiss in Chicago. Mr. Muchin was formerly an attorney with the Regional Counsel of Internal Revenue.

A DOCTOR . . .

totally or in part. This, in view of our present knowledge, should not be the case today.

Our scope of consideration and opportunities for our emotionally and mentally retarded children has been growing greater than at any time in the history of our civilization. We are beginning to demonstrate the recognition of their capabilities, their desires and their needs. Parents are becoming better educated, and in general, local organizations are more understanding of these groups of handicapped individuals. One has only to look at the recent federal budget provisions for mental health to point up the recognition that the entire country is more aware of the needs of these individuals.

The economic considerations of this part of our population has obviously made a tremendous impact. It is not unreasonable for one to demonstrate or think that our tax laws cannot keep up with the scientific investigations and conclusions of our rapidly advancing society. If educators and medical personnel recognize the necessity of providing the best educational programs possible, in keeping with our scientific findings, advances, and resources, then the support of the Internal Revenue Department in alleviating certain tax burdens should also be recognized.

Education in our schools is legally required for all children who are physically and mentally capable of profiting from the regular curriculum. We now recognize and recommend special education for those children who because of mental or physical handicaps are not able to profit from regular curriculum and may out of necessity require special facilities to meet their particular needs. It should be emphasized, however, that there is an alikeness of handicapped children to normal children, rather than their differences from normal children. They need all the advantages of normal children. They need individual attention in their teaching programs to adjust to life situations in a satisfactory and healthy manner, which may in addition provide a successful sociologic adjustment for not only the individual and his family, but also for the Government.

Some stern equitable considerations should be given those thousands of middle income individuals for giving support to retarded or emotionally disturbed children, remembering that those dollars being spent by individual families are far less than the amounts of money required under Government programs to care for the same individuals. To successfully treat and alleviate many of the conditions of emotionally and mentally handicapped children, one out of necessity requires scientific knowledge, skill, abundant patience, a genuine interest in the welfare of these children, and a recognition of the economic responsibilities imposed upon their families. Until the time is reached when tax laws clearly encompass and recognize the implications of our new medical horizons, physicians will have to satisfactorily, in detail, support all testimonies by clearly demonstrating the medical basis for the prescribed treatments of emotionally and mentally handicapped patients.

A LAWYER . . .

school problems were just assumed to be mentally slow where we are now finding that many of these children have emotional problems, which if corrected, would permit them to keep scholastically abreast of their peers.

The immediate problem, although this discussion may have wider application, comes about when parents discover their child cannot adjust to normal public school classes because of an emotional problem or because he is somewhat retarded. As to the latter children, we are speaking of those who have the ability to learn but are just slower than other children their age. In the *Olson* case *supra,* Judge Pierce framed the issue as being whether amounts expended for tuition and transportation for a mentally retarded dependent child, and for obtaining special individual training for the prime purpose of mitigating his mental deficiency and enabling him to acquire an ability to learn, after he had been expelled from public schools, is deductible.

The tax problem involved is not new; the

"key" to the availability of the sought after deduction is still the term "medical care." Section 213(e)(1)(A) of the 1954 Code (to which Code all references are made unless otherwise indicated) states that the term includes amounts paid for diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. This definition originally was contained in the Internal Revenue Code as Section 127 (a) of the Revenue Act of 1942. The Report of the Senate Finance Committee (S. Rept. No. 1631, 77th Cong., 2d Sess., p.6) said it was not intended "... that a deduction should be allowed for any expense that is not incurred primarily for the prevention or alleviation of a physical or mental defect or illness."

Persons in Institutions

The Commissioner's regulations specifically refer to persons in institutions. Reg. 1. 213-1(e)(v)(a) and (b). Under subsection (a) it is clear that a person institutionalized because of the medical care available at the institution can deduct the full cost, including any educational expenses involved. Subsection (b) provides that if an individual is in an institution and his condition is such that medical care is not a principal reason for his presence there then only that part of the cost attributable to medical care is deductible. One example given is a person in a home for the aged who is there for personal and family reasons and not because he requires medical attention. These regulations could be open to the interpretation that when a doctor advises that a change of scholastic climate, from a public school to a military academy, might be beneficial to a mental or emotional condition, the act of placing the child in such a school is done for the mitigation, treatment or prevention of a disease and that the child is going to that school primarily for the prevention and mitigation of a mental defect. The fact that the child is also learning is incidental to the main purpose of his attendance for he could learn just as well in a public school. Although the administrative problem of determining legitimate from non-legitimate deductions may be great, it can logically be argued that this should affect the deductibility of an expense that can be very costly to a person with a small or medium income.

The Commissioner has stated that the cost of sending a child to a place where the curriculum and disciplinary methods have a beneficial effect on a child's attitude is not deductible, Rev. Rul. 58-280, C.B. 58-1, 157. However, "attitude" and "emotional or mental illness" are not necessarily synonymous and a doctor's testimony should be able to clarify the difference. Are tranquilizers a better cure than an enforced environmental discipline?

The Commissioner has approved deductions for the cost of a woman's wig to improve her mental health when a disease caused her baldness. Rev. Rul. 62-189, 62-2, 88. It was specifically pointed out that the purchase of a wig to improve general health would not be deductible but the fact that a "disease" caused the baldness changed the situation. Again we think that a mental or emotional problem could be a "disease" and not just a "general health" problem.

The first case to discuss this problem in detail was *Commissioner v. Stringham*, 12 T.C. 580 (1949), aff'd. per curian 183 F. 2d 579. (6th CIR-1950). The Court there permitted a girl's parents to deduct all costs, except her educational expenses, incurred while she attended a boarding school in Arizona where the climate was beneficial to a respiratory ailment. The school did not provide medical treatment per se.

Additional Activities Nondeductible

The Court interpreted the Senate report referred to earlier to mean that amounts expended for general health or for the alleviation of physical or mental discomforts unrelated to some particular disease or defect were not deductible. The Court felt that there was a reasonable relationship between the change in climate and the care, mitigation and treatment of the child's disease. The educational expenses were held to be an "additional activity" unrelated to the disease.

This case would seem to support the deduction of at least some portion of the payments made to a private school for the type of child with whom we are concerned. It again appears that the practitioner's big-

gest problem is to get a Court to understand that an emotional or mental "disease" is as serious as a respiratory disease and a change in environment can be beneficial without a change in climate.

In *Gordon Pascal* T.C. Memo 1956-83 the Court held that without any identifiable physical or mental illness the cost of sending a child to a private boarding school was not deductible. There was testimony relating to a psychosomatic problem but apparently the Court did not think that was "identifiable"; and was worried about a different decision leading to "excessive abuses" in this area.

In another memorandum decision, *Everett F. Glaze,* T.C. Memo 1961-244 the Court felt that the taxpayer failed to prove a direct relationship between the tuition paid and an objective contemplated by Section 213. This in itself points out a problem that probably affects many of these cases and that is that these deductions are usually in the range of $1500-$3000 and are claimed by persons of moderate means who cannot afford to get the proper expert testimony. However, the Glaze's child did have brain damage, and it is doubtful if "brain damage" could be cured or alleviated by attendance at a boarding school. However, an emotional problem can be overcome and attendance at the same type of school could be a cure for a child with such a problem.

Parents who were able to send their child to a school that had psychologists on its staff, and which school specialized in treating gifted children who were emotionally disturbed, could only deduct the amounts actually paid to their doctors and psychologists. *Hobart J. Hendrick* 35 TC 1223 (1961) (Acq. C.B. 1962-2, 5). The Court disallowed a deduction for the other fees paid as it did not believe the child was sent to the school primarily to alleviate an emotional problem.

In *Martin J. Lichterman* 37 TC 586 (1961) (Acq. C.B. 1962-2, 5) the Court took a rather "hard" view toward an asthmatic child. It found that the school had no medical staff and that the availability of such care was not the main reason for the child's presence there. The Court held that the portion of the regulation providing that if the availability of medical care in an institution is not the primary reason for one's presence there limited the deduction to that part of the cost attributable to medical care.

In advocating the allowance of these deductions one might look to the cases involving home elevators. The expense of such a device was held nondeductible when it would not aid the taxpayer's paralytic condition, but would merely provide transportation, *Estate of C. L. Hayne* 22 TC 113 (1954). When it could be proven that the same elevator might prevent the recurrence of a heart condition its cost was deductible. *Hollander vs Commissioner.* 219 F. 2d 934 (3rd Cir. 1955). A litigant might argue that attendance at a private school should not automatically eliminate the deduction but the individual child's purpose in attending that school should control.

One for the Taxpayer

The two recent cases mentioned earlier reach what appear to be contrary conclusions, but unfortunately the one favorable to the taxpayer is a memorandum decision. In *Rolland T. Olson* T.C. Memo 1964-325, Judge Pierce allowed a full deduction for sending a mentally retarded child to a military school. Regular public and other private schools rejected the child but the owner of the academy involved agreed to attempt to educate the child. The child could only concentrate for very short periods of time, two to three minutes, so the head of the academy presented the child's instructions in small doses. Besides his low mental ability the child suffered from a super hyperactivity caused by a congenital mental deficiency.

There appeared to be no evidence that attendance at this school would improve the child's condition but that it was the only way he would gain any education. The Judge allowed the deduction on the basis that the child was prevented from pursuing a normal education and the principal reason for this training was not for education, but as medical training and therapy to overcome his handicap and stimulate his ability to learn so that he could undertake normal education and living.

One could well argue with the basis of the Court's decision for there does not appear to be any relation between this child's

attendance and the mitigation, care or alleviation of his disease or illness. It might be difficult to prove that the primary purpose for his attendance was to prevent a physical or mental defect. There was no evidence to indicate this child could ever be cured. It was just the best way of educating the child but that would not seem to warrant the deduction.

Epilepsy and Emotional Problems

In the *Atkinson* case, *supra,* the taxpayer's son, Andrew, developed epilepsy at the age of five. Three years later he began having trouble at school and was not getting along with his classmates. At the school's urging, he was taken to a psychiatrist who specialized in treating epileptic children. The doctor found that Andrew had "aggressive behavior" and was hostile toward authority which caused him to have difficulty with his teacher, classmates and parents. It was made clear to the Court that some of these problems were caused by his home environment and the doctor recommended Andrew be sent to a boarding school where he would be subject to a disciplinary system imposed by strangers.

The military academy he attended had no medical facilities. He spent three years there and at the time of his graduation from eighth grade his parents and the doctor felt he had made a marked improvement and was able to enjoy a healthy relationship with his parents and fellow students.

The connection between Andrew's epilepsy and emotional problems was not easily definable. His spells subsided while at school but were not cured. The doctor agreed that a child could have epilepsy without the accompanying emotional problems, but the two were somewhat related.

After examining the legislative history, the Court felt the deduction had originally been created strictly for medical expenses and not for items that are primarily personal. It cited the original Senate report *supra,* which said the expense was only deductible if created primarily for the alleviation of a physical or mental defect. The Court was unable to find that the condition of Andrew was such that the availablity of any particular care or resource of the special school was the principal reason for his presence. In other words, the Court could not be persuaded to take a broad view of the facts and conclude that the atmosphere provided by the rules, regulations and system of this academy, which admittedly could have been gotten at many others, was enough of a "resource" to conclude that this "resource" could alleviate an obvious emotional problem, and that the cost of attaining that help was deductible. The fact that a doctor "prescribed" this treatment, instead of pills or tranquilizers, was apparently immaterial.

A very recent Revenue Ruling, 65-255, I.R.B. 1965-46, 26, indicates that the Commissioner may be reevaluating Section 213. This Ruling permitted the taxpayer to deduct the cost of transporting his wheelchair-confined daughter to a public high school. The child's doctor stated that her attendance at the public high school was for psychotherapeutic purposes, namely; to keep her in school with children of her own age. The Ruling recognizes that the child could have received competent instruction at home. The tuition question did not have to be answered for a public school was involved, however, this Ruling seems to indicate that the Commissioner is beginning to recognize the medical value of psychological or emotional benefits.

Proper Testimony

Proper testimony couched in the medical terminology of the Code will help convince a Court that the deductions involved should be allowed. Medical deductions stand apart from entertainment, travel and other business expenses and a more liberal attitude favoring their deductibility might be warranted. The Courts have strayed away from the first steps taken in the Stringer case *supra,* and if new legislation or regulations are not forthcoming, enlightened and detailed testimony from physicians may represent the taxpayer's best opportunity for better tax treatment. Of course, if the Commissioner changes his position based on Revenue Ruling 65-255, *supra,* the taxpayer's problem could be greatly alleviated.

MALARIA
— a continuing problem

Martin S. Hirsch, M.D. and

Robin D. Powell, M.D./chicago

DESPITE CONSIDERABLE PROGRESS in efforts aimed at global malaria eradication, malaria remains a major public health problem in many parts of the world. Four patients with overt vivax malaria have been treated at the University of Chicago Hospitals during a recent four-month period. Three of the patients apparently acquired malaria in Africa, and the fourth in New Guinea. This brief report emphasizes the need to be alert to the possibility of encountering patients who have malaria.

Case No. 1

A 23-year-old Caucasian male graduate student was admitted to the hospital on 27 September 1965 because of chills and fever of four days' duration. He served with the Peace Corps in Liberia from September 1963 to July 1965. He had reportedly ingested weekly doses of chloroquine during that time. In December 1963 and February 1964, he experienced attacks of fever and chills, attributed to vivax malaria, which abated after treatment with chloroquine. He discontinued weekly ingestion of chloroquine in June 1965 and returned to the United States in August 1965. He was subsequently asymptomatic until he developed chills, profuse sweating, headaches, fever, weakness, and anorexia on 14 September 1965. Episodes of chills occurred daily each afternoon until his admission to the hospital four days later, at which time asexual erythrocytic forms of *Plasmodium vivax* were detected on examination of stained blood smears. Symptoms and patent parasitemia subsided within one day after initiation of treatment with chloroquine. The patient was treated with a three-day course of chloroquine and a 14-day course of primaquine. Symptoms of malaria have not recurred.

Case No. 2

A 24-year-old Caucasian male graduate student was admitted to the hospital on 8 November 1965 because of chills, fever, nausea and vomiting of six hours' duration. He served with the Peace Corps in Liberia from September 1963 to June 1965, and reportedly ingested weekly doses of chloroquine during this period. He developed an attack of chills, abdominal pain,

Department of Medicine, Division of the Biological Sciences, University of Chicago.

and myalgia in April, 1965, while in Liberia; these symptoms, attributed to malaria, had subsided after treatment with chloroquine. He discontinued weekly ingestion of chloroquine in June 1965 and returned to the United States in July 1965. Attacks of chills, abdominal pain, myalgia, and other symptoms occurred 21, 19, and two days prior to and on the day of admission to the hospital. Asexual erythrocytic forms of *P. vivax* were detected in stained blood smears. The patient received a three-day regimen of chloroquine and a 14-day regimen of primaquine. Symptoms and patent parasitemia subsided rapidly, and no recurrence of malaria has developed.

Case. No 3

A 27-year-old Caucasian male graduate student was admitted to the University of Chicago Hospitals on 11 December 1965 because of fever, which had occurred the previous day. He had been in New Guinea from December 1963 to March 1965 and said he had ingested chloroquine weekly from arrival until January 1965. While aboard ship returning to the United States in March 1965, he developed episodes of chills and fever occurring at 48-hour intervals. The patient was hospitalized in Seattle, Washington immediately after arrival in the United States. A diagnosis of vivax malaria was made, and the patient was treated with a three-day course of chloroquine and a 14-day course of primaquine. Symptoms subsided rapidly. The patient was subsequently well until fever, myalgia, and weakness occurred on December 10, 1965. A blood smear made during examination of the patient at the Student Health Service of the University of Chicago on December 10 disclosed asexual erythrocytic forms of *P. vivax*. The patient was treated with chloroquine for three days and primaquine for 14 days. Symptoms and patent parasitemia abated rapidly after initiation of therapy, and no recurrences have developed.

Case No. 4

A 26-year-old Caucasian male graduate student was admitted to the hospital on 27 January 1966 with chills and fever of four days' duration. He had been in Nigeria from September 1963 to August 1965 and said he ingested weekly doses of pyrimethamine during this period. In December 1963, he had a two-day episode of diarrhea and fever and a diagnosis of malaria was made after examination of blood smears. Symptoms subsided after treatment with antimalarial medication. In April 1965, he had a second episode of fever, chills, and diarrhea attributed to malaria; he was again treated with chloroquine, and symptoms abated. He subsequently ingested chloroquine weekly until two weeks after departure from Nigeria. He had no further symptoms until four days prior to admission when he developed chills and sweats lasting through the night. Symptoms recurred two days later and on the night of admission. Overt parasitemia *(P. vivax)* was demonstrated on examination of blood smears on admission. The patient was treated with a three-day course of chloroquine and a 15-day course of primaquine; symptoms subsided rapidly after initiation of treatment, and no recurrence has occurred.

Discussion

The four species of plasmodia known to cause naturally acquired human malaria are *P. falciparum, P. vivax, P. malariae,* and *P. ovale*. *P. falciparum* and *P. vivax* are the two most important species from a global standpoint. Early during the clinical course of either vivax (benign tertian) malaria or falciparum (malignant tertian) malaria, a classical periodicity of fever and chills may be absent. Fever may be remittent rather than intermittent, and symptoms other than fever may predominate. In non-immune individuals, symptoms of malaria may be marked when levels of parasitemia are low. Accurate early diagnosis is imperative, particularly in non-immune persons infected with *P. falciparum*. There may be a substantial risk of serious complications if falciparum malaria is not recognized quickly and if appropriate treatment is not instituted promptly. Repeated examinations of both thick and thin stained blood smears may be required to establish the diagnosis and to determine which species of plasmodia is involved.

The 4-aminoquinoline antimalarial drugs —notably chloroquine or amodiaquine— have been employed widely for treatment of acute attacks of malaria and for sup-

pression; these drugs are usually effective in relieving symptoms of malaria caused by any of the species of plasmodia that infect man. The administration of 1,500 mg of chloroquine base (equivalent to 2,500 mg of chloroquine diphosphate) orally over 3 days (600 mg of base initially, 300 mg 6 hours later, and 300 mg on each of the next 2 days) has been recommended[1, 2] for treatment of acute attacks of malaria in non-immune individuals.

"Clinical Cures"

Resistance of malaria parasites to chloroquine has not been detected among strains of *P. vivax, P. malariae, or P. ovale.* In mosquito-induced infections with these species of plasmodia, however, persisting or secondary tissue forms may develop which can give rise to relapses. Drugs such as chloroquine or amodiaquine, which do not destroy these persisting tissue forms of the parasite, may only temporarily relieve symptoms, effecting a "clinical cure" without completely eliminating parasites from the body. In individuals who ingest weekly doses of a suppressive drug such as chloroquine while residing temporarily in endemic areas, symptoms of malaria may be prevented as long as weekly ingestion of the suppressive drug is continued. However, acute attacks of malaria may ensue weeks or months after the individuals have returned to a non-endemic area and have discontinued ingestion of antimalarial medication. The patients discussed in this report vividly illustrate this point.

Two of the patients described in this report (Cases 1 and 2) experienced symptoms attributed to malaria while they were reportedly ingesting weekly doses of chloroquine in malarious areas, and one of the patients (Case 4) developed symptoms suggesting malaria on two occasions while he was ingesting weekly doses of pyrimethamine. Such instances do not necessarily constitute evidence of resistance of malaria parasites to drugs; the possibilities exist either that ingestion of prophylactic antimalarial medication was erratic or that the symptoms noted, although attributed to malaria, were caused by some other disease. Pyrimethamine exerts effects against several different stages in the life cycle of susceptible strains of parasites that cause human malaria, but is not a satisfactory drug for destroying persisting or secondary tissue stages of *P. vivax.*

Primaquine[3] is currently the drug of choice for elimination of persisting tissue forms associated with relapsing malarias such as mosquito-induced infections with *P. vivax.* The recommended regimen, consisting of administration of 15 mg of primaquine base (26.4 mg of primaquine phosphate) daily for 14 days, is usually adequate to destroy persisting tissue forms of *P. vivax.* However, persisting tissue forms of certain strains of *P. vivax* such as the Chesson strain of Southwest Pacific (New Guinea) origin are less susceptible to primaquine than are persisting tissue forms of many other strains, and repeated courses of treatment may be required to achieve "radical cure" or *complete* elimination of parasites from the body in infections with such strains.

"Radical Cures"

Because persisting or secondary tissue forms of the parasite apparently do not occur in infections with *P. falciparum,* drugs such as chloroquine, amodiaquine, or quinine, which act chiefly against asexual erythrocytic forms of the parasite, can effect a complete or "radical cure" of falciparum malaria provided that the asexual parasites are completely eliminated from the blood stream. Strains of *P. falciparum* resistant to chloroquine and to other synthetic antimalarial drugs have been detected recently in parts of South America (Colombia and Brazil) and Southeast Asia (Thailand, Malaya, Cambodia, and South Vietnam).[4, 5] Certain of these strains have proved resistant to all widely used antimalarial drugs except quinine. In individuals who have falciparum malaria and have recently been in areas where this problem has been detected, the possibility of an infection with chloroquine-resistant *P. falciparum* should be strongly considered.[4, 6] Although by no means an ideal antimalarial agent, quinine probably represents the best drug currently available for treatment of patients having acute attacks of malaria caused by chloroquine-resistant *P. falciparum.*

Summary

This report describes four patients who developed acute attacks of vivax malaria after returning to the United States from

malarious areas and who were treated at one hospital during a recent four-month period. A brief summary of pertinent aspects concerning the diagnosis and treatment of malaria is presented. The report emphasizes the need to be alert to the possibility of encountering patients who have malaria.

References

1. Covell, G., Coatney, G. R., Field, J. W., and Singh, J.: *Chemotherapy of Malaria.* World Health Organization Monograph Series No. 27, Geneva, 1955, W.H.O.
2. World Health Organization: Chemotherapy of Malaria. *Report of a Technical Meeting.* World Health Organization Technical Report Series No. 226, Geneva, 1961, W.H.O.
3. Alving, Alf S.: The Chemotherapy of Malaria, in Harvey, J. C., editor-in-chief: *Practice of Medicine,* Vol. III, Hagerstown, Maryland, 1962, W. F. Prior Co., pp. 634-644b.
4. World Health Organization: Resistance of Malaria Parasites to Drugs. *Report of a WHO Scientific Group.* World Health Organization Technical Report Series No. 296, Geneva, 1965, W.H.O.
5. Powell, R. D.: The Chemotherapy of Malaria. *Clin. Pharmacol. & Therap.* 7:48-76, 1966.
6. Editorial: Malaria. *J.A.M.A.,* 195:308-309, 1966.

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed double space and submitted in duplicate, one original and one carbon. An article should not exceed 12 to 16 pages, briefer if possible.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month, if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to: T. R. Van Dellen, M.D., Editor, Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601.

SMALLPOX VACCINATIONS COMPLICATIONS

John T. McEnery, M.D./chicago

THE INCIDENCE OF COMPLICATIONS following routine vaccination against smallpox is sufficiently high to warrant more careful appraisal of its necessity.[1] As recommended by the American Academy of Pediatrics, most children receive their first smallpox vaccination near their first birthday or during the second year of life. Most of the complications of eczema vaccinatum and vaccinia occur in children under four years of age.[2] The former is theoretically preventable if the vaccinating physician is more careful in selecting the children to be vaccinated.

The following case reports of children with eczema vaccinatum and vaccinia, treated with Vaccinia Immune Globulin (VIG) by the staff of the Cook County Children's Hospital, show that if a high index of suspicion is maintained, the appropriate therapy can be begun in the early course of the disease. The one death from overwhelming staphylococcal pneumonia points out the seriousness of routine vaccination of children against smallpox.

Case Report No. 1

C. A. was a 10-month-old Negro female who developed a rash on her forehead two weeks PTA. These lesions began as small papules which became vesicular. During the next two weeks successive crops of these lesions appeared and the rash spread to the face, neck, and shoulders. A few days prior to the appearance of the rash, she had received a smallpox vaccination in a well-baby clinic. There was no history of prior skin disease. Weight at birth was 1140 gms.

Physical examination revealed a 13-pound female with a rectal temperature of 100.8° F. There was an extensive umbilicated, vesicular rash over the face, neck, and shoulders. On the left shoulder was a fresh smallpox vaccination site covered by a crust. On the day following admission, she was given 3.6 cc of VIG. The next day she was afebrile and there were no new lesions noted. The skin was completely cleared by the eighth day of hospitalization. The child was concurrently placed in Bryant's traction for treatment of a fracture of the left femur, the cause of which was undetermined. Chest X-ray and urinalysis were negative. WBC 15,000 with N 30%, Lymp 50%, Mono 20%. Diagnosis: Vaccinia.

Case Report No. 2

A. R. was a 7-month-old Negro female who was vaccinated for smallpox two weeks PTA. One week PTA she developed a vesicular eruption on the neck, shoulders, and face. There was no previous history of skin trouble.

Physical examination revealed a mildly toxic female, weighing 17 pounds, with a rectal temperature of 99.6° F. There were numerous small vesicular and larger pustular lesions around the neck and face. Some

Associate Attending Pediatrician, Cook County Children's Hospital; and Instructor in Pediatrics, Stritch School of Medicine, Loyola University, Chicago.

of the lesions were kissing type in location. The large, individual lesions had an erythematous raised edge with crusting centers. On the left shoulder was a fresh vaccination scar from which the crust had recently fallen. She received 5 cc of VIG. Two days after admission no new lesions were noted. The older lesions dried in response to local therapy; she was discharged after seven days. A chest X-ray and urinalysis were normal. WBC 8,150 with N 28%, E 1%, Lymp 31%, Mono 40%. Diagnosis: Vaccinia.

Case Report No. 3

B. D. was a three-year-old Negro female admitted with an acute vesicular, pustular eruption over her face that began four days PTA. The lesions continued to develop over the next few days on the arms, legs, and body. Two days PTA she had a temperature of 102°. She had severe eczema which began when she was one month old, and she had been followed in the dermatology clinic. Her 10-month-old sibling had been vaccinated against smallpox two weeks earlier, and the scab had just fallen from her arm.

Physical examination showed an acutely ill female weighing 28 pounds with a temperature of 104.8° F. by rectum. Her face, neck, and flexor surfaces of her arms and legs showed chronic lichenification. On the face, neck, and arms were numerous, grouped papulovesicular lesions with umbilicated centers. Treatment was begun with KMnO4 local, wet, dermatological dressings; aspirin; IV fluids; and Terramycin. The evening of the day of admission she received 10 cc of VIG. Four days after admission, the lesions were drying and IV fluids were discontinued. Because of a daily spiking temperature, prostaphlin (Staphcillin) 375 mg q6hrs P.O. was begun. Fine crepitant rales were heard in the right chest on the sixth hospital day. She was still spiking a temperature of 102° F. Her respirations became more labored, and she expired suddenly on the evening of her eighth hospital day.

Laboratory data: WBC 7,650 with 22% N, 35% Bands, 8% Eos, 20% Lymps, and 15% Mono. Hb 9.7% gms. with 3.98 mil RBC. Urinalysis normal. Post mortem examination revealed extensive right lower lobe pneumonia. Hemolytic staphylococcus aureus, coagulase positive was grown from the material taken from the lung at autopsy. Diagnosis: Eczema Vaccinatum.

Case Report No. 4

C. S. was a three-year-old Negro female who was admitted with a temperature of 104° and an acute vesicular eruption over the face and neck for two days PTA. Since the age of 11 months, she had been followed in the dermatology clinic for a chronic dermatitis of the flexor surfaces of her arms and legs. Her admitting room diagnosis was Infected Atopic Dermatitis. On the ward it was discovered that her brother, who slept in the same room, was vaccinated two weeks before in a well-baby clinic.



Figure 1: Case 6, Eczema Vaccinatum

Physical examination showed a toxic female weighing 38 pounds with weeping, vesicular, umbilicated lesions over the face and neck. There were enlarged cervical lymph nodes. Her temperature was 105° F. per rectum. Therapy was initiated with IV fluids, KMnO4 baths, penicillin, and aspirin. Ten hours after admission she received 10 cc of VIG by injection. Marked improvement was noted on the day following admission, but she continued to spike temperatures up to 102° F. until the fourth day of hospitalization. Hemolytic staphylococcus aureus, coagulase positive was grown from material taken from the skin lesions. It was sensitive to Penicillin. She was discharged on the fourteenth day of hospitalization. Urinalysis was negative. CBC on the tenth day: Hb 11.5 gms, WBC 9,100 with N 34%, stabs 3%, Eos 1%, Lymphs 60%, and Mono 2%. Diagnosis: Eczema Vaccinatum.

Case Report No. 5

R. P. was a nine-month-old Negro male who had had eczema since the age of two months. He developed a papular, vesicular rash over his face and body five days prior to admission. His mother thought it came from contact with a wool rug. He had had a fever of undetermined degree for two days.

Physical examination revealed a toxic appearing male infant with extensive papulovesicular lesions over the entire body. The face was more severely involved with occlusion of both eyes due to cellulitis. There was marked cervical adenopathy. The vesicles were umbilicated. He weighed 18 pounds, 4 oz. and had a temperature of 103° F. by rectum. Although no history of recent exposure to a fresh smallpox vaccination was obtained, VIG was obtained and he was given 10 cc IM the afternoon of the day of admission. Further treatment consisted of KMnO4 dressings, IV fluids, aspirin and penicillin. On the second day of hospitalization his temperature was still 102° F. No new lesions were noted and the older vesicles had begun to dry. Because of a few new vesicles and continued fever, he was given an additional 5 cc of VIG on the fourth hospital day. On the sixth day he was afebrile and no new lesions were found. His skin cleared rapidly, and he was discharged on the 20th day of hospitalization. Later it was discovered that another child in the same household had been recently vaccinated, and she had been carrying the patient.

Laboratory Findings: Chest X-ray and X-ray of long bones showed rickets possibly due to his hypoallergic diet. Urinalysis was normal. CBC: Hematocrit 44%, RBC 4,160,000, WBC 8,500 with N 20%, Bands 38%, Lymphs 34%, and Monos 8%. Diagnosis: Eczema Vaccinatum.

Case Report No. 6

S. P. was a ten-month-old Negro female who developed a vesicular rash on her face five days PTA. On the day prior to admission she had been seen in the outpatient clinic, and she had received IM penicillin and Benedryl for her infected eczema. Past history revealed that she had had a papular rash on the face and flexor surfaces of her arms and legs since the age of three months.

On admission the child had a diffuse papulovesicular eruption over the left side of her face. The extensive cellulitis caused closure of the left eye. Her temperature was 105° F. by rectum, and she weighed 17 pounds. The umbilicated lesions were in groups and had an erythematous base. No history of exposure to recent smallpox vaccination was elicited from the



Figure 2: Case 6, 48 hours after VIG

mother. The child was treated with IV fluids, aspirin, KMnO4 dressings, and Cloxicillin 100 mg q6hrs. On the next day, after discovering that the patient's eight-year-old sister had been vaccinated by a school physician two weeks previously, VIG was obtained and she received 5 cc that afternoon. Her temperature returned to normal by the third hospital day, and the skin lesions were drying. She was discharged on the 15th hospital day.

Laboratory Findings: Skin culture: hemolytic staphylococcus aureus that was sensitive to penicillin and methicillin. Urinalysis was normal. Chest X-ray was normal. CBC: Hb 8.7 gms, RBC 4,000,000. WBC 6,151 with 62% N, 4% Stabs, 23% Lymphs, 11% Monos. Diagnosis: Eczema Vaccinatum.

Case Report No. 7

M. H. was a nine-month-old Negro female who was admitted with a temperature of 102° and an acute weeping, vesicular eruption over her face for three days. She had been treated for atopic dermatitis since the age of two months.

Physical examination revealed a toxic Negro female weighing 19 pounds, 3 oz. with a temperature of 101° F. by rectum. There was a weeping, crusting, pustular eruption over her face, neck, and the flexor surfaces of her arms. No history of recent smallpox vaccination in her family was elicited on admission. She was treated with Staphcillin, IV fluids, aspirin, and dermatologic wet dressings of KMnO4. She continued to spike a temperature up to 104° over the next three days. At this time it was noted that the lesions were becoming more umbilicated. Further questioning of the family revealed that a neighbor's child, with whom the patient had been playing, had been vaccinated recently. On her third day of hospitalization the patient received 5 cc of VIG. Her temperature returned to normal on the fifth day, and there was drying of the vesicles. She was discharged on the thirteenth day of hospitalization.

Laboratory Findings: A skin culture grew non-hemolytic staphylococcus aureus, coagulase positive that was sensitive to chloramphenicol and methicillin. Urinalysis and chest X-rays were normal. CBC: Hb 9.7 gms, RBC 3.85 mil, WBC 28,500 with 61% N, 5% Stabs, 3% Eos, 23% Lymphs, and 8% Monos. Diagnosis: Eczema Vaccinatum. (Note: Virus culture positive for vaccinia. Performed by Mr. Morrisey of the Illinois State Laboratories, Chicago, Ill.)

Comment

As demonstrated in Cases No. 3 through No. 7 with Eczema Vaccinatum, the diagnosis is often unsuspected when an acute pustular, weeping eruption occurs in a child with a previous history of eczema. All of the children were admitted with an admitting room diagnosis of eczema with secondary pyogenic dermatitis. In all of the five cases the true diagnosis was suggested when the patient was seen by the attending physician, but in one case this did not occur until the third day (Case No. 7) because of the intervening weekend.

The history of exposure to a fresh smallpox vaccination must be searched for carefully. The widespread, umbilicated, grouped, papulovesicular eruptions on an erythematous base (Figure 1) should suggest the diagnosis of Eczema Vaccinatum. The response to Vaccinia Immune Globulin (VIG) is often dramatic. The child with eczema since the age of three months (Case No. 6) was often carried by her eight-year-old sister who was vaccinated by a school physician following her entry into a new school. After receiving 5 cc of VIG (0.6 cc per kilogram of body weight) there was marked clearing of the orbital cellulitis and drying of the facial

lesions within 48 hours (Figure 2). Kaposi's Varicelliform Eruption must be included in the differential diagnosis.

Case No. 3 died suddenly of an acute staphylococcal pneumonia while receiving therapeutic doses of Prostaphlin (Staphcillin). At the time of her death, the skin lesions of Eczema Vaccinatum had begun to dry following the use of VIG.

Discussion

The last reported case of smallpox in this country occurred in 1947 in New York. The recent "case of smallpox" in Washington, D. C., in May 1965 (subsequently proven to be varicella) and the extent to which the public health authorities mobilized all available resources to vaccinate all possible contacts was well publicized in the popular press. This "case from Ghana" points out two facts: (1) that children in the pre-school age group are not at risk at the present time, and (2) that it is possible to prevent an epidemic by the immediate vaccination or re-vaccination of all possible contacts.

The success of the quarantine regulations enforced by the U. S. Public Health Service has contributed greatly to the freedom of this country from the importation of smallpox. The ready identification of the virus in the laboratories of the Communicable Disease Center and others by the electron microscope enables the diagnosis of variola major to be made in suspect cases within the 12-day incubation period. Protection against smallpox is best maintained by repeated vaccination of those at risk, i.e. our hospital personnel, travelers to endemic areas, and those persons working in airports and other ports of entry. The fatalities that have occurred in well-vaccinated Europe have been among nurses and physicians, i.e. those at high risk.

In 1963 there were approximately 3,000 complications with 10 to 18 deaths among a total of 14 million persons vaccinated.[3] Vaccinia, a self-limiting condition with mild symptoms, accounted for the majority of these complications. It is readily terminated by VIG.[4] The bulk of the morbidity and mortality from Vaccinia is caused by Vaccinia Eczematum and Vaccinia Gangrenosum (progressive vaccinia) —two preventable complications. These also respond to therapeutic dosages of VIG. Occasionally chemotherapy with methisazone may be necessary to control the complications.[5] Our children with Eczema Vaccinatum required twice the hospital stay as those with generalized vaccinia.

Since there is no smallpox in the United States, vaccination, being an elective procedure, must be done with a more cautious approach. Children with eczema or living in a household with siblings who have eczema; children with agamma-globulinemia, leukemia, or receiving steroid or antimetabolite therapy should not be vaccinated. If necessary, routine vaccination may be performed during the second year of childhood, since the incidence of mortality from post-vaccinial encephalitis is highest in the youngest children.[3]

Summary

Vaccine Immune Globulin has been used in seven children who developed complications following smallpox vaccination or contact with a fresh smallpox vaccination, and who were admitted to the Cook County Children's Hospital during the past two years. The wisdom of continued routine smallpox vaccination of children with minimal risk of contact with the disease is questioned, especially in view of the fact that five children with long-standing eczema developed Eczema Vaccinatum following exposure to a fresh smallpox vaccination.

The death of one of these children could have been avoided if her sibling had not been vaccinated in accordance with recommended immunization procedures.

References

1. Kempe, C. H.: An Evaluation of the Risks of Smallpox Vaccination in the United States, Paper read before the American Pediatric Society, Philadelphia, Penn. May 6, 1965, Abstracted in *J. of Pediat.* 67:1017-1022 (Nov) 1965.
2. Neff, J.: Epidemiology Intelligence Officer, Personal communication July, 1965.
3. Kempe, C. H. and Benenson, A. S.: Smallpox Immunization in the United States, *JAMA* 194:161-166 (Oct 11) 1965.
4. Sussman, S. and Grossman, M.: Complications of Smallpox Vaccination. Effects of Vaccinia Immune Globulin Therapy, *J. of Pediat.* 67: 1168-1173 (Dec) 1965.
5. Bauer, D. J., et al: Prophylactic Treatment of Smallpox Contacts with N-methylisatin B-thiosemicarbizone (compound 33T57 Marboran), *Lancet* 2:494-496 (Sept 7) 1964.

Further Studies on Placebo Management of Skeletal Disease

C. B. Thrift, M.D. and
E. F. Traut, M.D./oak park

Rapid multiplication of new remedies confuses both patient and doctor. Many of the newer drugs currently accepted with enthusiastic but inadequate study have iatrogenic effects. One must balance the possible good to come from the use of a drug against its harmful effects. Especially is this true in evaluation of therapy in arthritis, a chronic disease as subject to remissions and exacerbations as the waves of the sea. Suggestion may increase the patient's faith and security to account for the improvement or even remission of the disease.

In 1959 we started to use placebo tablets consisting of lactose 0.3 gm. after each meal during the first week of the work-up of a new patient in our free clinic to endeavor to determine the placebo reactors and obtain a base line for therapy. All other medication was stopped. We found the lactose tablets did not affect the sedimentation rate, serum uric acid or the number of eosinophils in the peripheral blood. With a patient claiming and demonstrating improvement on the "white tablets," another week's supply was given. Seven physicians in the clinic interviewed the patients trying to be as objective as possible. Lack of benefit from the tablets led to a weekly injection of 1 cc of normal saline solution. Failure to improve while receiving injected placebo was followed by current, conventional anti-arthritic or anti-rheumatic drugs, diet, physio-therapy, hygienic and surgical advice. During weekly visits care was taken to avoid rhetorical or leading questions. Equivocal or apologetic replies were classed as placebo failures.

Patients and Placebo

A large percentage of patients with rheumatoid arthritis immediately resisted the placebo. This percentage of placebo resistors is higher than in degenerative arthritis (75% as against 52%).

Patients' improvement on oral placebo was largely subjective. The patients were improved objectively, but not to the same degree as their subjective symptoms, with a marked discrepancy often observed between the effect upon the symptoms and upon the objective changes in the disease. Regarding objectivity in skeletal disease, it is worthwhile noting the strong subjec-

tive element in "tenderness." Even "stiffness" is strongly subjective. "Swelling," on the other hand, is purely objective. Improvement in the erythrocyte sedimentation rate lagged considerably behind other evidences of remission. The patient often volunteered the information that there was improvement in sleeping, eating, bowel action, and general well-being coincident with the relief of his arthritis. About one-fourth of the patients complained that the lactose tablets were "just like aspirin" in causing nausea or tinnitus.

Increasing the dose of saline above 1 cc did not affect the results. The saline solution was routinely injected in the region of the deltoid muscle. Many patients claimed more relief when the injections were given proximal to the affected part. The patients' reports were about evenly divided as to the time when improvement was noted; in about half the improvement was immediate and in the rest it was felt four to six hours after the injection. About one-third of the patients claimed that the relief from the injections lasted only about 72 hours, and were gratified by receiving the injections twice weekly.

How Not to Use a Placebo

An example of how not to use a placebo is worth reporting. A patient showing progressive improvement on placebo injections was sent to a nursing home and the nurse in charge indignantly refused to administer the helpful saline injections, telling the patient "Why, it is just salt water."

Eleven patients with psychalgia, a psychogenic rheumatism, who were expected to respond most brilliantly to placebos, merely yielded figures comparable to those found in rheumatoid arthritis. Four patients with shoulder-hand syndrome, were not relieved by placebo tablets.

In general, the recent studies are confirmatory of our early investigations. Two hundred seventy-one patients, 103 males, 168 females, received placebo for one week to ten years. The largest number, 245, had degenerative arthritis. Of these, 58% improved on three daily tablets containing 0.3 gm. of lactose. The tablet failures and those reporting only minimum benefit comprised 131 patients. These received weekly injections of 1 cc of normal saline solution. Sixty-nine per cent of these injected patients improved.

Rheumatoid Arthritis

Rheumatoid arthritis was represented by 101 patients. Of these, 49% improved on the tablets. Sixty-three per cent of the rheumatoid patients failing to improve on the tablets were subjectively and objectively benefited by the injected saline. Fifty patients had rheumatism diagnosed as fibrositis, arthralgia and low backache of skeletal origin. Of these, 25 patients improved on the lactose tablets. Seventeen of the 25 patients receiving placebo injections improved. These figures and percentages agree closely with those of our studies reported in 1959.

The propriety of using placebo medications to determine placebo reactors has been established by many authors such as Beecher. Despite a greatly increased amount of research, the etiology of the placebo effect is not yet understood. The physician's interest in the patient (autosuggestion) and his treatment is a major determinant of placebo effects. You will recall treatments previously used and even current which have given results in 70% or less of the patients treated, the "tiresome" 70% mentioned by Dr. Fishbein. For example, Dr. Herrick years ago made stool cultures of colon organisms patterned after Dr. Cecil's work. He gave this vaccine to 250 patients with all forms of arthritis and reported a 64% cure rate.

From our study we continue to be impressed by the remissions and exacerbations characterizing the natural course of arthritis. Therefore, we feel that should the patient be entering a remission and you administer such a drug as Indomethacin or any other measure, you may ascribe the resulting remission to the use of Indomethacin whereas in reality the remission would have occurred had nothing been given.

Placebos satisfy the patient's desire to start treatment immediately during the inevitable interim of laboratory tests. Charting the patient's suggestibility establishes a base line for estimating the truly chemical or pharmacologic value of any agent. Finding the placebo procedures of no benefit or the development of placebo resist-

ance, are indications for institution of other measures.

The question of ethics always arises in every study of the placebo effect. We considered the use of supposedly inert substances justified after listening to thousands of patients reporting on the negative effects of the whole mass of empirically used chemicals and procedures, many known to be harmful. In general we teach that it is in the best interest of the patient to give him the drug or chemical with the least iatrogenic effect to bring about a remission. This was stressed by Hench years ago who always endeavored to bring about a remission with salicylates in rheumatoid arthritis, using cortisone only when salicylates failed.

In conclusion, from our studies we feel it is a necessity to use placebos in any study of drug effects. We further conclude that the number of rheumatoid patients found to benefit from placebo in our ten year study is about the same as the number favorably influenced by many methods of therapy reported in other studies. Placebo benefit of significant degree was sufficiently evident in a large enough group of patients to justify its continuance.

References

1. Beecher, H. K. (1955). *J.A.M.A.*, 159:1602
2. Lasagna, L.; Mosteller, F.; von Felsinger, J. M. and Beecher, H. K. (1954). *Amer. J. Med.*, 16:770
3. Leslie, A. (1954). *Ibid.*, 16:854
4. Ross, O. B. (1951). *J.A.M.A.*, 145:72
5. Traut, E. F. and Passarelli, E. W. (1956). *A.M.A. Arch. Int. Med.*, 98:181

From the Arthritis Clinic of the Cook County Hospital and Hektoen Institute for Medical Research.

HEALTH CENTERS? I'VE GOT ONE IN MY OFFICE

A recent article in the *New England Journal of Medicine* described the operation of a large university clinic and noted the cost of a routine clinic visit as over $9.00. I wrote to the editor: "I see patients for less than this in my office. So do most other doctors." The author replied: "Of course the unit cost per patient visit in a university medical center is greater than that in a solo private medical office. The complex equipment and specialized personnel of the teaching medical center, which makes possible a wide variety of resources for the care of the complicated patient, causes continuous increases in the unit costs."

But what about patients whose illnesses aren't that complicated and who do not need all this complex equipment and specialized personnel? Financially, they are better off going to a physician's office where their needs can be met in less elaborate and costly ways.

A popular theme today and one that's favored by federal legislation to establish "centers of excellence," is that medical care should be centralized in hospitals. But this proposal ignores the fact that runaway hospital costs have far outdistanced the price of medical care anywhere else.

. . . A patient who had been treated in a large medical center once told me: "They had a doctor for my head, a doctor for my stomach, a doctor for my lungs, a doctor for my heart, a doctor for my back, a doctor for my rectum and other doctors for other parts of my body. But they didn't have a doctor for me." *Edgar Rosen, M.D., Medical Opinion and Review, March 1966.*

THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

This 35-year-old white male patient entered Cook County Hospital with a complaint of a progressively enlarging mass on the lateral upper aspect of his left leg of about four months' duration. On further questioning he recalled that he had been hit on the leg by a large shipping cart while at work and had noted a bruise which only "hurt for a day or two."

Physical examination revealed a grapefruit sized mass in the upper one-third of the leg. All other physical findings were normal.

A femoral arteriogram was done. (Figure 1)



Figure 1

Diagnosis: False aneurysm of the anterior tibial artery.

There was a tear in one wall of the anterior tibial artery with extravasation of blood (contrast media) into a loculated hematoma which caused compression and spreading of the anterior and posterior tibial arteries. At surgery, 400 cc. of hematoma was evacuated and a segmental resection of the lacerated artery was performed.

Reference

Beck, M. E.: Arteriography in Peripheral Trauma. Clin. Radiol. 14:235-239, 1963.



A CHAMPAIGN-URBANA MEDICAL SCHOOL

A university medical center for Champaign-Urbana is a subject seldom discussed in state medical journals, in the state legislature, or in meetings of university officials, despite overwhelming reasons, herein enumerated, that a second state university medical center could well serve Illinois. As a house officer, I appreciated the wonderful educational opportunity at the University of Illinois Medical Center in Chicago. From all over the state come patients suffering from the rare and the common. Often they have been previously treated in closer university centers in St. Louis, Iowa City, Indianapolis, Louisville. Wouldn't it be ideal if there were a second University of Illinois medical center, downstate in Champaign-Urbana, and in close relation to the main University of Illinois campus?

"Ah, but no," replies Lucretia, the well known Chicago academician. "The Megalopis Theory of Medical Education states quite clearly that all medical colleges must be in metropolitan areas in order to insure a large population of sick patients and plenty of polluted air. The next Illinois medical school should obviously be in Chicago or its suburbs, despite the already crowded conditions and even if we must build the school around a private hospital without university affiliations. Let 'em talk about science and culture and all that nonmedical stuff; all we need to produce from our doctor factories is somebody who can make a diagnosis and who knows where to look up drug dosages. If we could only get a computer to make the diagnosis . . ."

There are, however, many university medical centers which serve a rural population. I am most familiar with the University of Florida College of Medicine, which is located in Gainesville, Florida, a community considerably smaller than Champaign-Urbana. Although one does not see the volume of cases available in Chicago at this rural university medical center, there are sufficient interesting referral

cases for the fledgling physicians to observe. The location of the University of Florida College of Medicine in Gainesville, chosen over the uproar of the Florida Lucretias, provides a service to the practitioners and the population of the surrounding rural area, educates physicians for future generations, and produces important research through its close association with the main body of the University of Florida.

The time has come to build a medical school in Champaign-Urbana. An academic institution is needed to serve the rural population of central Illinois and to provide a referral center for the difficult and interesting cases of the long-suffering private practitioners. A medical school contiguous with the great state University of Illinois will create an interplay beneficial to both. The great pool of talent already present at the University will provide the scientific and cultural fabric for the illumination of medicine in its total perspective. The presence of medical scientists and patients will undoubtedly stimulate the University's physical and life scientists to direct their productive research to problems of human disease. The time has come to build a medical school in Champaign-Urbana.

Frank R. Freemon, M.D.

THE LABELING OF MEDICINE

The Council of Drugs of the American Medical Association recently made the following suggestion relative to the labeling of medications:[1] "The Council resolves that it favors labeling of prescriptions as a general practice, and furthermore, it is recommended that prescription pads contain boxes for a yes or no on whether to label; if these boxes are not filled in by the physician, the prescription will be labeled."

Taking a definite stand on this positive recommendation may not have the same effect as opening Pandora's box but we believe there is merit in labeling all medications. Many tend to forget that materia medica has changed considerably in the past two decades. There are so many drugs today that it is impossible to recognize the majority on sight; a high percentage can be toxic and cause severe reactions. In addition, many are now categorized as hazardous.

Labeling medicines also goes along with change in medical practice. Many patients, for example, are being seen by more than one physician. A general practitioner is better able to treat a cardiac emergency if he knows that the heart specialist or fellow physician down the street previously prescribed an anticoagulant, a powerful new diuretic, or antihypertensive drug. The same can be said of antidepressants, tranquilizers, or even nitrates, quinidine and digitalis.

Treatment by more than one physician is common in group practice and is increasing among the solo physicians because of the increase in travel and accidents. The use of cardiac drugs also adds to the hazards of surgery and contain combinations that have synergestic or bizarre side reactions.

What are the objections to labeling medicine? Some physicians object because the patient will be frightened or disappointed by the knowledge he is getting a certain remedy. Others are concerned that it encourages self-medication or lays the ground work for a law suit. A few are concerned with their competition. The modern prescription is not compounded and most of our patients can, if they wish, read the name of the drug on the blank. In addition, the use of the generic name will obviate much of the objections. And our ever increasing senior citizen group still has many whose memory is failing. They couldn't remember the name if you told them but what happens when they take an overdose or have an accident and the family must call someone else because the family physician cannot be found.

T. R. Van Dellen, M.D.

Reference

1. Council on Drugs: To Label or Not to Label. *J.A.M.A.* 194:143, 1965.

SUMMARY OF ACTIONS



1966 HOUSE OF DELEGATES

1966-1967

OFFICERS AND BOARD

Officers

President	Caesar Portes, 25 E. Washington St., Chicago 60602
President-Elect	Newton DuPuy, 1101 Maine St., Quincy 62301
1st Vice President	Noel G. Shaw, 2901 Central Ave., Evanston 60201
2nd Vice President	Paul W. Sunderland, Gibson City 60936
Secretary-Treasurer	Jacob E. Reisch, 1129 S. 2nd St., Springfield 62704

House of Delegates

Speaker of the House	Edward W. Cannady, 4601 State St., E. St. Louis 62205
Vice Speaker	Maurice M. Hoeltgen, 1836 W. 87th St., Chicago 60620

Board of Trustees

1st District	Carl E. Clark, 225 Edward St., Sycamore 60178.....1968
2nd District	Ralph N. Redmond, 101 E. Miller Rd., Sterling 61081.....1968
3rd District	Philip G. Thomsen, 13828 Lincoln Ave., Dolton 60419.....1969
	William M. Lees, 7000 N. Kenton Ave., Lincolnwood 60646....1968
	Frank J. Jirka, 1507 Keystone Ave., River Forest 60305.....1968
	J. Ernest Breed, 55 E. Washington, Chicago 60602.....1969
	William E. Adams, 950 E. 59th, Chicago 60637.....1967
	Ted LeBoy, 330 Gale Ave., River Forest 60305.....1967
4th District	Paul P. Youngberg, 1520 Seventh Ave., Moline 61265.....1967
5th District	Darrell H. Trumpe, St. John's Sanatorium, Springfield 62700..1967
6th District	J. Mather Pfeiffenberger, 200 W. 3rd St., Alton 62004.....1969
7th District	Arthur F. Goodyear, 142 E. Prairie Ave., Decatur 62523.....1967
8th District	Wm. H. Schowengerdt, 301 E. University Ave., Champaign 61821 1967
9th District	Charles K. Wells, 117 N. 10th, Mt. Vernon 62824.....1969
10th District	Willard C. Scrivner, 4601 State St., E. St. Louis 62205.....1969
11th District	Joseph R. O'Donnell, 444 Park, Glen Ellyn 60137.....1968
Trustee-At-Large	Burtis E. Montgomery, 37 S. Main, Harrisburg 62946
Chairman of the Board	Arthur F. Goodyear, 142 E. Prairie Ave., Decatur 62523

ADMINISTRATIVE ACTIVITIES

Report of the President

Both the published report in the Handbook, and his oral report to the House, reflected the sincerity and dedication which was paramount during the term of Dr. Burtis E. Montgomery as President of the Society. The need for cooperation, the futility of criticism without participation or constructive thinking, the dedication of the few in the support of all phases of society activity, were the basic subjects Doctor Montgomery presented.

Report of the President Elect

The acceptance speech of Dr. Caesar Portes outlined ten items about which he plans to concern himself during his term of office as president of the State Society. (1) the image of the profession; (2) a positive program to answer some of the criticism made of the profession; (3) cooperation and understanding of the problems faced by private insurance companies; (4) development of active and well informed society committees; (5) adequate use of our hospital emergency rooms; (6) cooperation with the deans of the medical schools and the need for general practitioners; (7) liaison between the Board and members of the Society; (8) nonpartisan participation in politics; (9) cooperation with the American Medical Association to strengthen the organizational structure; (10) the maintenance of a profession as free from socialization and unnecessary governmental controls as is possible.

Vice Presidents

Both vice presidents reported active participation in Society activities, and regular attendance at meetings of the Board, and sincere and sustained interest in the affairs of medicine.

Report of the Secretary

The importance of the appearance of officers and members of ISMS staff before county medical societies to keep the personal line of communication open was stressed. Without the invitation of the local society, it is impossible for the headquarters office to schedule these appearances, and more societies should take advantage of the willingness of both busy officers, trustees and staff members to appear and assist all physicians in having definite information regarding the many-faceted profession they serve.

Report of the Speaker and Vice Speaker

The report of the Speaker and Vice Speaker outlined several plans under way to expedite the business of the house—changes in the work of the Committee on Credentials; the introduction of resolutions by title; the important briefing session of the chairmen, staff and secretarial personnel on the opening day.

The most important phase of activity which has been added, is the Trustee District meeting held just prior to the opening of the House. It is hoped that this meeting will be the means of developing a better informed group of delegates, and perhaps supply the answer to some of the questions resulting from the inability to schedule reference committee meetings at staggered hours.

The handbook, "Your Role as a Delegate" met with approval.

Report of the Chairman—Board of Trustees

The chairman of the Board presented highlights of the important items considered by the Board, and not covered in the reports of the various society committees. The selection of committee members met with approval of the House. The Opinion Research Study was approved and the Board complimented for initiating the activity. The need for scheduling new activities and establishing priorities for society projects was recognized.

The Board will continue to keep in close touch with the deans of the five medical schools in the Chicago area, and will work to acquire support for grants to open a new medical school outside the Chicago area.

Report of Policy Committee

The House approved the material presented in the Policy Manual, and also the supplementary report published in the handbook clarifying the policy regarding group examinations in physicians' offices. The statement added was: "This general statement does not apply to the industrial or occupational health physician in his in-plant activities."

Committee to Study Committees

The House approved the recommendations presented by the Committee to Study Committees and charged the committee to work with the Committee on Constitution and Bylaws to remove all committee elections from the Bylaws, prepare the suggested changes and present them to the House in May of 1967. The basis for this action was outlined by the Committee to Study Committees:

This would make it possible

- To discharge inactive committees without changing the Bylaws
- To enlarge committee personnel when indicated
- To replace inactive committee personnel annually or when the committee requests such action
- To combine committees without changing the Bylaws
- To eliminate dual membership on all committees

and still have the House of Delegates, through the system of annual reports and policy manual

supervision, maintain a general control of committee policy and procedure.

Husband-Wife Membership billing

The Resolution providing for joint billing of husband-wife dues in the ISMS and the Auxiliary was approved if the COUNTY SOCIETY SO DESIRES. This procedure is used in many states to assist the Auxiliary in building up its membership, and in providing a simple means of dues collection for the women.

Conflict of Interest

There was considerable discussion relative to "conflict of interest" within our membership. No examples were cited. The reference committee "reminded members of the official family that should one find himself in a position of conflict of interest, he should remove himself from that item of business." None of the resolutions dealing with this subject was adopted.

Training of Volunteer and Staff Leadership

The House approved a resolution which requested that a special study be made of the future leadership responsibilities and needs for the state and county societies, including the mechanisms and budgetary means which may be employed in order to fulfill the leadership role which medical men must continue to develop.

The Board of Trustees was instructed to implement such a study "to the extent possible within present financial rsources and render a progress report at the 1967 meeting."

ADMINISTRATIVE ACTIVITIES

Finances

The question of the finances of the Illinois State Medical Society are the center of much concern, the focal point of whatever criticism comes to the organization and its officers, trustees and staff, and of course, of paramount importance to all the membership.

This committee, aware of the importance of their assignment, made every effort to clarify and delineate all phases of the financial structure of the Illinois State Medical Society.

Some of the items considered were the proposed increase of $25 in AMA dues for 1967, which will be presented before the House of Delegates in regular session in Chicago in June. The importance of this proposal was such that Dr. F. J. L. Blasingame, Executive Vice President of the AMA, appeared before the House on Sunday and outlined the existing need and the proposed areas in which this money, if and when secured, would be expended. The reference committee approved the five resolutions recommending that the $25 increase be approved, that ISMS present a resolution to this effect before the AMA House, and support it in reference committee and on the floor.

The suggestion that no dues increase be voted in Illinois State Medical Society except at the regular annual meeting, would make it impossible to raise money (as was done in the ELDER CARE program) as part of the dues structure. Any additional funds would have to be secured as an "assessment"—which, of course, would not be deductible for income tax purposes. The reference committee felt that this resolution, and the one asking that any dues increase be outlined, with support data, at least 90 days before the House meets, should receive study and consideration. Since such action would require changes in the Constitution and Bylaws, the two resolutions were referred to this committee for study and report at the next annual meeting in 1967.

The attention of the House was called to the fact that both "Pulse" and "What Goes On" are completely subsidized and cost the Society nothing. However, bookkeeping necessitates showing cost and income on both.

The detailed budget is to be mailed to each county medical society at least 60 days prior to the annual meeting of the House of Delegates. This is to be in lieu of the "summaries" as published in the Handbook.

The $20 from the annual dues for AMA-ERF represents about the only unrestricted funds available to the deans of the medical schools and in many cases is used in supplementing salaries and for necessary unbudgeted expenditures. The reference committee agreed that this should be continued. The acceptance speech of the check for the five schools, by Dr. Richard Young of Northwestern, outlined much of the background and expressed personally the thanks for the schools. Dr. John Sheehan of Stritch and Dr. Granville Bennett of Illinois Medical School were both present in the House, an excellent indication of the interest these men are expressing.

The House approved "direct billing for voluntary contributions" such as the $25 for public affairs purposes. This also has been approved at AMA level, and in this manner the House felt that each physician could make his own decision as to whether or not he cared to pay the contribution.

The ISMS ended 1965 in the black $9,640; under the budget for 1966 $8 is to be placed in a permanent reserve fund; $7 to the Benevolence; $20 to AMA-ERF, and $70 into General Funds from which all society activities are budgeted.

The House did not agree that any refund of dues should be allowed societies employing a lay executive, however, a continuing study is to be made by the officers and staff of ISMS

concerning future development of District Field Offices to provide better "in-the-field" services.

The assignment of $1 per year per member to raise some $50,000 for the Archives Committee project "Shrine of Documents and History" in the old Capitol Building in Springfield, was rejected. This assignment of funds was contingent upon raising some $85,000 additional money from outside sources, which has proved impossible. The House felt this was impossible without an increase in dues.

There are several problems faced by the Rural Health and Student Loan Fund Committee involving the ten places reserved for freshmen students at the University of Illinois. The program was established by an act of the legislature, and is under study at this time. The committee will report further.

The reports of the AMA Delegation, the Educational and Scientific Foundation, and several other resolutions referred to this committee received careful consideration, and the House approved the complementary statements presented for action.

REFERENCE COMMITTEE ON CHANGES IN CONSTITUTION AND BYLAWS

At the suggestion of the reference committee, the House approved mailing quarterly financial reports to all members of the House of Delegates and officers of component societies. The House particularly requested that this information be brought specifically to the attention of the county society membership.

As a matter of policy, the speaker of the House was asked to appoint to the reference committee considering administrative activities, whenever practical, at least two members who served on the committee at the previous annual meeting. A background and knowledge of the budget, the financial statements, etc., is a distinct advantage to any physician who is a member of this committee.

Other changes include:

- Membership on the Board of Trustees for the Speaker of the House
- Election of county society delegates prior to December 31 and a report to ISMS headquarters by January 15
- The term of office of all delegates will begin on January 1, following election.
- All officers of component societies shall forward its roster of officers and members and the names of their delegates and alternate delegates to headquarters office before January 15.
- Annual dues are to be paid on or before March 1
- Members are delinquent immediately after the first of March, and shall be dropped automatically on June 30.
- The speaker of the House was empowered to name such reference committees as he deems necessary to cover the reports sent to the House for its consideration

The House reaffirmed the basic principle that discrimination on the basis of race, color or creed had no place in organized medicine at any level. The portion of one resolution which requested a change in the constitution of the AMA to provide that "membership in the AMA of any constituent association shall be revoked if such constituent association shall allow any component society to deny membership to any individual on the basis of race, creed or color" was discussed. The House called attention to the fact that the request is unconstitutional. Under the Bylaws of ISMS, the county society is the sole judge of its members.

The House agreed that all ethical and qualified physicians should be eligible for membership, but pointed out that this resolution would effect a new line of command in organized medicine by taking away the local autonomy and giving it to a strong central power.

LEGISLATION AND PUBLIC AFFAIRS

The work of the Impartial Medical Testimony Committee was given high praise by the House. This means of clearing the courts has been used frequently during the year, and 30 of the latest 80 cases in which impartial medical testimony was used, have been recommended by court judges.

The report of the Medical Legal Committee has been excellent. The House approved the recommendation that an appropriate followup be made to the studies currently in progress of malpractice screening mechanisms recently inaugurated in other areas.

The House abolished the Liaison Committee to the Department of Registration and Education since it is no longer being used.

The House recommended that the Industrial Hygiene Unit of the Department of Labor be transferred to the Department of Public Health as "The Division of Occupational Health" since this is a medical, not a labor problem. The Board has been asked to so recommend.

The Committee on Laboratory Evaluation was requested to (1) provide each practicing physician in the state of Illinois with a list of approved laboratories, and (2) through the Committee on Legislation, work to secure an amendment of the Medical Practice Act to define clearly the performance of clinical laboratory procedures as a part of the practice of medicine.

The Committee on Narcotics was complimented highly for the success of the first joint conference on narcotic addiction.

The House recommended that a consulting board to advise with FDA consisting of distinguished physicians, pharmacologists and chemists be established and made available to work with FDA with respect to the introduction of new therapeutic agents and devices as well as the restricting of useful drugs now on the market. The Illinois delegates to the AMA were asked to introduce such a resolution at the AMA meeting in June 1966.

The House approved as a matter of policy that the physicians on the Illinois Advisory Council for Heart Disease, Cancer and Stroke be appointed on a regional basis throughout the state, using the Trustee Districts as geographical areas, and that at least one physician from each trustee district be so appointed.

(The attention of the House was called to the fact that the Governor's committee had already been appointed and had physician representation with fair geographic distribution.)

ECONOMICS AND INSURANCE

Several reports were presented to this committee as reports of information and progress, requiring no action. They were printed in the April issue of the Illinois Medical Journal, and should be read as matters of information. This is true of the Committee on Aging, the Liaison Committee to Blue Cross–Blue Shield, Rehabilitation Services, Hospital Relations, Fee Schedules, and Medical Economics.

The House approved the resolution sent from Macon County Medical Society asking that the ISMS instruct an appropriate committee to study, with the intent to justify the action taken by the hospitals in Macon County classifying the information on hospital medical records as a privileged communication and as the property of the hospital.

While the importance of the Illinois Department of Public Aid program cannot be stressed too often, the committee itself had no requests in the report published in the April Journal. It was a report of progress, and the House accepted it as such.

The resolution concerning dietary provisions for recipients of public aid was referred to the Committee on Nutrition for further study.

The House approved designating the Department of Public Health as the agent under the medical aspects of Title XIX.

The Drug Manual was discussed in detail and the fact that 98% of the requests for drugs not already listed were granted was called to the attention of the House. A loose leaf format has been developed and the House gave commendation to the committee for its fine work.

The House agreed to support the objectives of the hospital-based specialists relative to "specialty billing." Also, the House urged that physicians serve on Hospital Utilization Review Committees because (1) in accepting a staff position in a hospital, the physicians should assume the responsibility of taking on utilization review duties and responsibilities in the same manner as serving on other staff committees, and (2) in regard to utilization review under the Medicare program, participation in utilization review is a necessary responsibility of physicians so as to preserve the availability for medical needs for beds and patients of all ages.

The House approved the recommendation that 100% of the usual and customary fees be used as the basis for negotiations with all governmental and private agencies. The House discussed this problem as it pertained to the IDPA. Under Title XIX physicians would *not* be allowed to bill medical assistance patients for the additional 20% of the reasonable charge while that patient was a recipient of any form of public assistance. (The IDPA agreed to pay 80% of the "reasonable charges" on the same basis as the intermediaries pay under Part B of Title XVIII.)

Then the means for determining "reasonable —usual—customary" fees were discussed both at the reference committee meeting and before the House. The Social Security Administration feels that the charge for a service usually or most frequently made by an individual physician who furnishes covered services would constitute "customary charge." The SSA refers to that part of the total range of fees which includes the most frequently and most widely used charges in a locality for a given medical procedure or covered service, as the "prevailing charge," and has directed the intermediary to organize information on prevailing fees charged by the specialist and the non-specialist, identifying the physicians who are Board Certified or who are Board eligible, and classifying others who may limit their practice to specialty areas.

Any charge which exceeds either the "customary charge" or the top of the range of "prevailing charges" for a service would be deemed "reasonable" by the Administration ONLY in the exceptional case when objective evidence supports the amount of the additional charge. According to the Administration, fee schedules might be used in determining reasonable charges where they are acceptable in the locality, in which case they may be "prevailing charges."

Methods of Payment

The law, PL 89-97, allows two methods of payment to physicians under Part B, and it is up to the individual physician and his patient to decide which method is used.

(1) Method I allows the physician to bill the

patient direct, and the patient is fully responsible for the full payment of the obligation.

(2) Method II allows the physician to accept an assignment of benefits in which case he will bill the carrier and be reimbursed by the carrier directly.

Under either method, the carrier will pay 80% of what it determines is the "reasonable and customary charge for the services rendered, less the $50 annual deductible," which is the responsibility of the patient.

If the physician chooses Method I and bills the patient direct, he is under no obligation to accept anything less than what he bills his patient. It is the responsibility of the patient to meet the obligation of the physician's bill.

The physician may employ both methods and vary them as he sees fit.

The House of Delegates approved the recommendation of the Committee on Usual and Customary Fees, and the Reference Committee which concurred, that the ISMS RECOMMEND TO ITS MEMBERS THAT IT IS PREFERABLE FOR THEM TO BILL THEIR PATIENTS DIRECT RATHER THAN TO ACCEPT AN ASSIGNMENT OF BENEFITS UNDER TITLE XVIII, Part B, of PL 89-97.

Determination of Reasonable Charges For Professional Services

The Continental Casualty Company, the intermediary in Illinois, requested approval to send a one page questionnaire to Illinois physicians outside of Cook, Kane, Lake, DuPage and Will counties, asking them to list the fees they charge for a small number of services and procedures they perform and to indicate their name on the questionnaire.

This particular subject probably caused more discussion on the floor of the House than any of the other problems faced by the delegates. After amendments to the effect that this request should apply not only to Continental but to any other intermediary, and the fact substantiated that ISMS would be consulted in the drafting of the questionnaire and the implementation of the study, the vote was put on the recommendation of the reference committee as amended. The House did not approve the request and did not concur in the recommendation of the reference committee.

PUBLICATIONS AND SCIENTIFIC SERVICES

The Illinois Medical Journal was reviewed by this reference committee, and the Journal Committee commended for the excellence of its effort of continued emphasis on economy, while at the same time, doing everything possible to develop the Journal in all areas. The House approved the resolution asking that all classified advertising (especially that pertaining to positions for physicians) be screened carefully and that the IMJ not accept classified advertising whereby the arrangement between the party seeking a physician's services and the physician would constitute the unethical practice of medicine.

The Committee to Study Conventions was asked to continue its efforts and was urged to continue to discuss merging the CMS Clinical Conference and the ISMS convention.

Many of the reports were those of progress and information—The Committee on Continuing Education, Eye Health, Ad Hoc Committee on Medical Education, Mental Health, Nursing, Nutrition, Perinatal Mortality, Radiation, Standard Vital Certificates, etc.

The House concurred in the recommendation that the hazards occurring from accidental use of the Laser Beam be a subject for study and perhaps new legislation.

Official action approved the vital necessity to promote good environmental health and to assist in the training of sanitarians in every way possible.

The report of the Maternal Welfare Committee relative to the modernization of the existing Illinois law pertaining to abortions was referred back to the Maternal Welfare Committee for statistical study and precise delineations with report back to the Board and the House in 1967.

The House recommended the continued allocation of AMA-ERF funds to the five medical schools in Illinois, after talking to a representative of the AMA, refrained from requesting a study of the rates of interest charged and the methods of repayment for AMA-ERF loans to students, concurred in the importance of more general practitioners, and commended the Child Health Committee for its interest in the physically abused child, and the efforts to obtain cooperation from all coroners in reporting cases where a child is found dead by a physician or DOA at a hospital.

The House approved and agreed with the statement that more trained sanitarians are needed. A committee was recommended to explore and promote the development of curricula and individual courses of study which would answer this need. All facilities of the education community, including community colleges and state universities are to be encouraged to assist in providing for these needs.

PUBLIC RELATIONS

The House concurred in the recommendation that the Advisory Committee to the Health Careers Council of Illinois, the Advisory Committee to the Student American Medical Association and the Physicians Placement Service

be combined under one committee with subcommittees appointed to work with HCCI and the SAMA chapters. This was referred to the Committee to Study Committees for implementation.

The House approved the suggestion that two types of legislation could well be supported—the first would limit the sale of automobile license plates to automobile owners who have adequate liability insurance and the second would require all automobiles three years or older, to have semi-annual inspections with the issuance of windshield decals to indicate approval for road transportation. These two suggestions were referred to the Committee on Legislation for study and report.

The House asked that the Grievance Committee provide a more detailed breakdown regarding the nature of complaints received, which would enable the reference committee involved as well as the House to evaluate better the problems affecting the image of the physician.

The Disaster Medical Care Committee was commended for its diligent and devoted efforts, and was asked to continue its programs, including the promotion of fallout shelters, the emergency hospital program and the medical self-help training.

The Committee on Medicine and Religion was asked to coordinate its projects with the Federation of Churches; and the Fifty Year Club Committee was commended upon the excellent program provided this year.

The request for additional financial support for the Health Careers Council of Illinois was discussed in detail. The work of the Council was approved, and the committee's request for an increase in financial support to HCCI in proportion to the increased support of the other 21 organizations working with HCCI, was referred to the Board of Trustees for consideration. The request was made contingent upon the availability of ISMS funds at the end of the year, 1966.

MISCELLANEOUS BUSINESS

The Code of Interprofessional Relations for Physicians and Pharmacists was discussed in detail, and after some serious consideration, it was the opinion of the House that the entire Code should be tabled.

A "new scientific membership" was requested from the AMA, but since it would cause a schism in the ranks of medicine and weaken the efforts of the profession when an atmosphere of unity should prevail, the resolution making such a suggestion was not adopted.

The need for lay executives at the county society level was discussed, and the House felt that this need should be the responsibility of each county medical society to determine whether or not such services should be made available. The responsibility is at the local and not the state level; however, district service areas and the possibility of extended services from the ISMS are under study by order of this House, and this matter was referred to the Board of Trustees.

Opinion polls were discussed. Since the House of Delegates represents the medical profession throughout the state and should certainly be able to speak for the constituents, the real need for "opinion polls" should be a matter of serious and careful consideration, and should not occur frequently under any circumstances. Members should be encouraged to use channels within the existing structure of organized medicine to make their opinions known, and the fact that expressions of duly elected representatives of the state and territorial societies which comprise the AMA, are truly representative, as expressed by the "majority vote" or any democratic organization was stressed. The matter was referred to "an appropriate committee."

ACTION ON RESOLUTIONS

1966 HOUSE OF DELEGATES

RESOLUTION NUMBER	INTRODUCED BY	SUBJECT	ACTION
66M-1	Jackson County	Action by House relative to Annual dues	Referred to Const. & Bylaws Comm.
66M-2	Madison County	Cooperation with HEW under PL 89-97	NOT adopted
66M-3	Madison County	New Scientific Membership for AMA requested	NOT adopted
66M-4	Vermilion County	Usual & Customary Fees for Services Rendered	Adopted
66M-5	M. R. Saxon	Free Society Philosophy Program for Education	No action
66M-6	George C. Turner	Tuberculosis Vaccination	Tabled
66M-7	Board of Trustees Wm. E. Adams, Chmn.	Joint Husband-Wife Membership in ISMS & Auxiliary	Adopted
66M-8	Will-Grundy County	Support for Health Careers Council	Adopted
66M-9	Will-Grundy County	Drug Manual of IDPA	NOT adopted
66M-10	Saline-Pope-Hardin Co. Society	Approval of $25 Increase in AMA dues—1967	Adopted
66M-11	Whiteside County	Approval of $25 Increase in AMA dues—1967	Adopted
66M-12	DuPage County	Rotating Internship	Adopted
66M-13	DuPage County	Enlargement of Preceptorship Programs	Adopted
66M-14	DuPage County	Direct Billing under PL 89-97	Adopted
66M-15	DuPage County	Direct Billing—Pathologists	Adopted as amended
66M-16	DuPage County	Direct Billing—Radiologists	Adopted as amended
66M-17	Macon County	Tax Supported Medical Services	NOT adopted
66M-18	Macon County	Availability of Hospital Records to Ins. Carriers	Referred to "appropriate committee"

RESOLUTION NUMBER	INTRODUCED BY	SUBJECT	ACTION
66M-19	Will-Grundy Co.	Need for lay Executives at county society level	Referred to Board of Trustees
66M-20	Will-Grundy Co.	Opinion Polls at state & national levels	Referred to ''appropriate committee''
66M-21	St. Clair County	Approval of 1967 increase in AMA annual dues	Adopted
66M-22	Madison County	Medical Aspects of ''Head Start'' projects	WITHDRAWN
66M-23	Madison County	Conflict of Interest rulings for ISMS officers & trustees	NOT adopted
66M-24	Board of Trustees	AMA-ERF Student Loan Interest Rates	NOT adopted
66M-25	Section on Pathology G. L. Seitzinger	Ethical classified advertising	Adopted
66M-26	Madison County	Scheduling of reference committee meetings	NOT adopted
66M-27	Winnebago County	Professional Med. Services in hospitals	Adopted as amended
66M-28	Greene Co. Medical Society	Approval 1967 Increase in AMA annual dues	Adopted
66M-29	Kane Co. Medical Society	''Conflict of Interest''	NOT adopted
66M-30	LaSalle County	Approval 1967 Increase in AMA annual dues	Adopted
66M-31	J. E. Reisch for Comm. on Student Loan Fund & Rural Health	Medical School Curriculum & emphasis on General Practice	Referred to Com. for further study
66M-32	Richland County	No automatic billing for voluntary contributions	NOT adopted
66M-33	Winnebago County	Need for trained sanitarians	Adopted
66M-34	Winnebago County	Establishment FDA Supervisory Board	Substitute Resolution Adopted
66M-35	Whiteside County	Physician membership on Advisory Council under PL 89-239	Adopted as amended
66M-36	Richland County	AMA-ERF Contribution from ISMS	NOT adopted
66M-37	Quentin D. Young, Herbert Ratner, A. E. Joslyn, R. R. Cross, Burton Soboroff, A. S. Klinger	Amendment to AMA Constitution & Bylaws to eliminate discrimination	No action taken
66M-38	Winnebago County	Maintain present AMA dues structure	NOT adopted

RESOLUTION NUMBER	INTRODUCED BY	SUBJECT	ACTION
66M-39	Winnebago County	Reduction of ISMS dues for 1967	NOT adopted
66M-40	Alfred D. Klinger for South Side Branch CMS	Dietary provisions for recipients IDPA	Referred to "appropriate committee" for study
66M-41	Alfred D. Klinger for South Side Branch CMS	Membership application regulations	No action taken
66M-42	McLean County	Disposition of State Society Funds	Adopted
66M-43	Peoria Medical Society	Conservation of ISMS Funds	Adopted
66M-44	Peoria Medical Society	AMA dues increase to be deducted from ISMS dues	NOT adopted
66M-45	Peoria Medical Society	Refund of ISMS dues to Co. societies with lay executives	NOT adopted
66M-46	Madison County	Curriculum to stress opportunities for GP	Adopted as amended
66M-47	Joseph O'Donnell	Training & development of Volunteer & Staff leadership	Adopted
66M-48	Board of Trustees	Designation of Dept. of Health-Agent under Title XIX	Adopted
66M-49	Peoria Medical Society	90 days notice for any dues increase	Referred to C. & Bylaws
66M-50	Kane County	Individual responsibility plan	NOT adopted
66M-51	DuPage County	Conflict of interest	NOT adopted
66M-52	DuPage County	Conflict of interest under PL 89-97	NOT adopted
66M-53	DuPage County	Liaison between state & county societies	No action taken
66M-54	Richland County	Commendation for Participation in Public Affairs (personal for one individual)	No action taken
66M-55	Adams County	Youth Education	Adopted

Highlights of the 126th Annual Convention

2880 Attend Convention

Physicians	1725
Guests	480
Woman's Auxiliary	325
Technical Exhibitors	270
Scientific Exhibitors	80

President Addresses House of Delegates

Dr. Burtis E. Montgomery, ending his year as ISMS president, addressed the House of Delegates and challenged physicians to "reaffirm our position to preserve the traditional doctor-patient relationship and resist all efforts by others to invade that prerogative."

He noted that we are facing a very critical period in medicine because of the threat of Medicare's expansion in the very near future.

Excerpts from his address follow:

"When I became president of the Illinois State Medical Society in 1965, I didn't realize how quickly a year could pass. They say the more you enjoy your work the faster time passes. If that's true, then I must have completed the shortest, most satisfying 12 months of my life.

"During that time, I have attended over 50 meetings, traveled over 20,000 miles and devoted hundreds of hours of work to help make our state medical society a vital, effective force in medicine, as well as public affairs. And while I found the assignment most rewarding, I must confess that —after a year of hard work—I am a tired doctor.

"I am tired of insinuations of narrow-minded critics who interpret the motives of our continuing fight against socialized medicine as selfish.

"I am tired of political attempts to divide and conquer our profession by classifying the work of some physicians as hospital services.

"I am a tired doctor—nauseated by political attempts to destroy the system of medicine that has given our country the highest quality of medical care ever achieved.

"I am a tired doctor—weary of fighting the battle against socialized medicine with only a handful of devoted, hard-working supporters, while the majority of our members sit back and fail to help us in carrying out our mutual goals.

"I am weary of the sighs and moans of those few who have 'given up' and are willing to accept the so-called inevitable. Just because we lost the first round against Medicare, doesn't mean we've lost the entire fight. In fact, war has just begun as



New ISMS President, Dr. Caesar Portes (left) is welcomed into his new position by outgoing President, Dr. Burtis E. Montgomery at the final session of the House of Delegates. The presidential medallion worn by Dr. Portes was presented by Dr. Edward A. Piszczek.

evidenced by President Johnson's statement last month that he 'sees no reason why Medicare shouldn't be expanded to include everyone in this country, the young as well as the old.'

"I am a tired doctor, all right . . . tired of hearing members, who can't find time to read the materials we send them, complain that we're not doing anything . . . complain that their dues are too high.

"Perhaps if these physicians would have exhibited the same fight in opposing coverage under Social Security as they do our state dues, they would not be contributing over $5 million this year to Social Security. That's right: our 10,000 members this year will pay over $5 million into Social Security, a program which the majority of our members disagreed with.

"Compare this with the approximately $750,000 annual operating expenses of your state medical society, an organization structured to meet your specific needs and desires, an organization dedicated to serving you, an organization comprised of physicians, by physicians and for physicians, an organization which performs hundreds of different types of services on your behalf.

"Yes, I am a tired doctor . . . tired of hearing that organized medicine should 'do something' about this and that from members who neither have the time or the desire to serve on our committees.

"With the Medicare program only six weeks away from implementation, and threats of its expansion in the very near future, we are facing a very critical time in medicine, in the state and the entire nation. What direction do we plan to take? Where will we concentrate our activities? Where will we invest the bulk of our efforts?

SAMA Representative Thanks ISMS

Representing the five Chicago Student American Medical Association chapters, James Liljestrand, member of the Northwestern Medical School chapter, expressed appreciation for the society's support and counsel during the year. He reported that the second annual SAMA-ISMS-CMS conference, attended by over 300 medical students and guests, has won many friends for organized medicine and has been a tangible shot in the arm for the individual SAMA chapters.



Dr. Warren H. Cole, Chicago (right) received the first Edwin S. Hamilton Teaching Award for outstanding medical teaching from the man for whom the award is named, Dr. Edwin S. Hamilton of Kankakee. The honor will be given annually by the Interstate Postgraduate Medical Association of North America. Dr. Cole has been head of the Department of Surgery at the University of Illinois College of Medicine for the past 30 years.

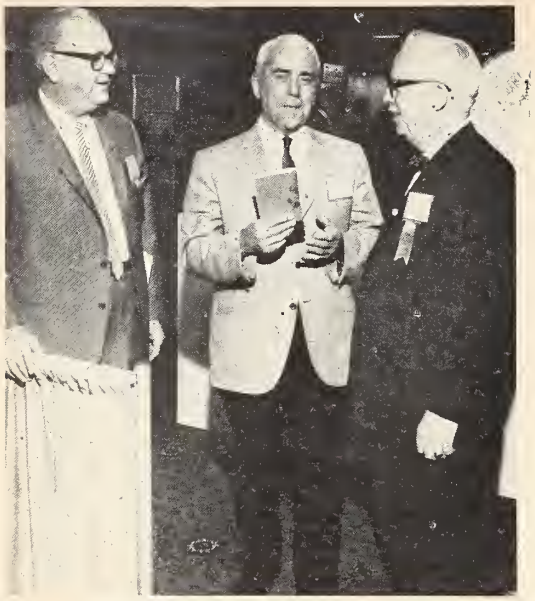
Music and Entertainment Are Applauded

More than 600 doctors, their wives and guests, enjoyed a "Salute to the Gaslight Era," the party that replaced the traditional annual banquet. Two Dixieland bands played for dancing continuously, except during breaks when specialty acts entertained the crowd. A free sandwich bar was popular.

Radiology Exhibit Wins Aesculapius Award

Mead Johnson Laboratories presented a $200 check and its Aesculapius Award plaque to E. R. Grigg, of the Cook County Hospital Radiation Center, for his exhibit "Historical Synopsis of American Radiology," citing it as the most outstanding scientific exhibit at the 1966 convention. Cited for educational significance were: Rafael M. Garces and Robert A. Carlin for "Bone Scanning with 85-Stronium and its Clinical Application"; Isa Sejdinaj and Richard C. Powers for "The Surgical Treatment of Stroke"; and D. A. Abramson, L. S. W. Chu, S. Tuck, Jr., S. W. Lee, G. Richardson and M. Levin for "Clinical and Experimental Aspects of Motor Nerve Conduction Velocity."

Originality awards went to Lothar Hussman, H. W. Kienast and Louis D. Boshes



Columbia's Dr. F. W. Gebhardt (center) assists Dr. Burtis E. Montgomery (right), outgoing president of ISMS, in opening the scientific and technical exhibits for the convention. Dr. Leo P. A. Sweeny looks on.

for "Ultrasound Diagnosis—Theory and Practice"; Robert H. G. Monninger for "Adjuvant Therapy in Ocular Trauma Sequel"; and to Y. Takimura, M. R. Lichtenstein and J. R. Thompson for "Photochromogenic Mycobacterial Pulmonary Infection in Chicago."

Dr. Blasingame Comes Before House of Delegates

Dr. F. J. L. Blasingame, executive vice-president of the American Medical Association, appeared before the 1966 ISMS House of Delegates to give background information on the proposed AMA dues increase.

He explained that when the AMA House of Delegates meets in Chicago in June, it will take final action on a recommendation of the Board of Trustees to increase annual AMA membership dues by $24, from $45 to $70, effective January 1, 1967.

The recommendation was considered by the House at the AMA clinical convention in Philadelphia, December 1965. The committee which considered the proposal reported to the House of Delegates that it was in agreement with the Board of Trustees that "it is not realistic to expect that we can limit tomorrow's programs to yesterday's income."

After floor discussion, the House of Delegates voted approval of the Board recommendation, subject to final action by the House. Following are excerpts from the AMA white paper on the subject:

"The American Medical Association is a not-for-profit, professional, scientific organization engaged in services to the medical profession and the general public. But the AMA is also a 'business' organization —an employer and property owner—as inextricably caught as any other in the upward price spiral and as buffeted as any other by inflationary forces which have cut the purchasing power of the dollar by more than 50 percent in the last quarter of a century. Just as the costs of operating a physician's office have increases, so have the costs of running the AMA.

For example: since 1960 paper, printing and postage is up 181 percent; real estate taxes, up 200 percent; office furniture, up 7-10 percent; other office supplies, up 10-15 percent; starting salaries for office employees in the Chicago area, up 25 percent; Social Security taxes, up 72 percent, with additional increases built into the law; bulk mail rates, up 20 percent. Inflation which has been adopted as a national policy, is a growing economic burden.

"It should be noted that membership dues now provide less than 28 percent of AMA income. If the AMA did not have other sources of income, the current level of programs for the profession and the public would require annual dues of $165 per member.

"AMA dues compare favorably with other organizations, particularly labor unions, some of which require members to pay up to 1.5 percent of annual gross salary.

"The budget has been reviewed exhaustively by the Board and by the headquarters staff. Wage and salary increases have been minimized and all travel and meeting costs have been reduced by 10 percent. Some programs have been curtailed and some deferred. The Association has progressively increased revenues from sources other than dues.

"By 1970, more than a dozen new medical schools will have opened so that the growing physician population constantly adds to the Association's membership service programs. Record keeping also increases. And more physicians generate

new demands on the Association for continuing education.

"People want more health information and they expect the medical profession to provide it.

"The enactment of a series of laws designed to give government vastly more power in financing of health care has placed on the AMA additional obligations and responsibilities that cannot be met without increased revenue.

"What the individual physician gets from membership in the AMA depends partly on the physician himself. Some of the benefits are provided for as a matter of routine; others are available for the asking. Some can be valued in terms of dollars; others cannot."

Opinion Research Report

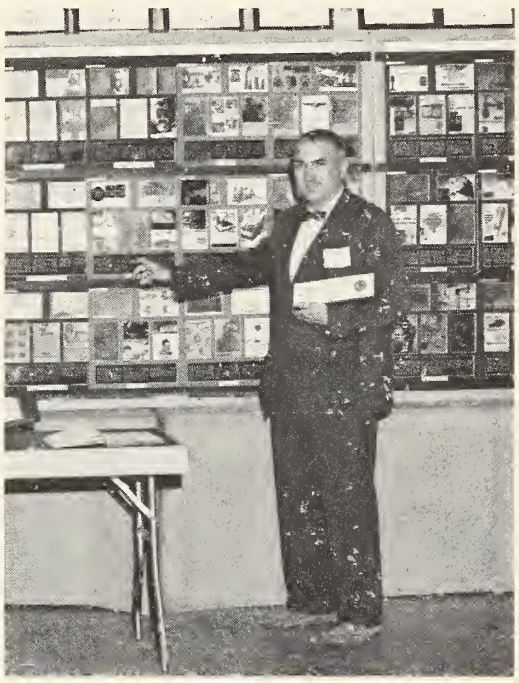
The Opinion Research Corporation, Princeton, N. J., which has been conducting a survey among members of the Illinois State Medical Society on their attitudes toward the society and its activities, presented the results of this appraisal to the 1966 House of Delegates. The research included 1145 interviews with a representative sample of ISMS members. Two hundred of these were personal interviews; 945 were conducted by mail.

The survey revealed that a large number of the society's members is not taking advantage of the services available and appears to lack interest in participating in the affairs of organized medicine at any level. Those interviewed were asked to rate the value of membership in the Illinois State Medical Society and various aspects of the society's program. Those who are acquainted with the society's services use them to advantage. But many others appear to be disinterested and apathetic. When asked about the need for the state medical society five years from now, 51 percent said they thought the need would be greater than it is now.

The implications of all attitudes revealed by the survey will be studied in depth by the society during the coming year and will guide the Board of Trustees in making policy.



Dr. O. W. Pflasterer (right) of Coulterville presents a check for $200 from the Randolph County Medical Society to the Educational and Scientific Foundation of ISMS. Receiving the check is Dr. Burtis E. Montgomery, immediate past president.



Champaign's Dr. E. R. N. Grigg explains his display "Historical Synopsis of American Radiology" which won the first annual Mead Johnson Award for the best scientific exhibit. The display was sponsored by the Cook County Hospital Radiation Center.

Public Affairs Speaker Blames Government for Inflation

The president of the American Farm Bureau Federation, Charles B. Shuman, speaking at the annual Public Affairs Dinner, said the government—not farmers and other economic groups—is causing inflation.

"It's time the Johnson Administration quit blaming others for the inflation that

government itself is causing,'' Shuman said.

He stated that the Administration's ''arm twisting'' campaign to secure adoption of a rent subsidy proposal ''typifies its stubborn determination to spend for every phase of the Great Society program while at the same time financing a war in Viet Nam.

''It is sheer hypocrasy for responsible spokesmen in government to plead for curbs on private spending when the Administration is the champion spendthrift of the nation,'' he said.

Shuman maintained farmers are being ''hit from two directions'' by the Administration: government inflationary spending policies driving farm production costs up and executive agencies issuing orders which put a lid on farm market prices.

Camp Lecturer Discusses Nation's Military Strength

The nation must maintain its ''position of strength'' until a ''realistic and workable'' disarmament system is found, William M. Mebane, Ph.D., secretary of Thiokol Chemical Co., said in the seventh annual Camp Memorial Lecture.

There is no value in ''joining the fringes who would have us unilaterally do away with our defenses,'' Dr. Mebane continued.

Expressing the hope that the ''resurgence of ethical faiths'' will restore people behind the Iron Curtain to the company of religious society and make such disarmament feasible and workable, Dr. Mebane said ''there is not fault in the great ethical principles; the failure of man lies in his unwillingness to live by them.''

Dr. Mebane noted that now we live in an era where war is ''unacceptable'' even to the theoretical winner; consequently, we are forced to emphasize ''other tools of diplomacy.'' This is why, he explained, that there is more emphasis on foreign aid, reduction of colonialism, new adventures in international trade, growth of cultural exchanges and new methods of communication for the propagandizing of national and world images.

It is also why the space program ''cannot be debated'' as a question of expenditure versus value. Historically, until now the bigger and more powerful the man, the more he had his way. But all men are the same size in front of a gun.

The inventions of various weapons have caused the rise and fall of empires and cultures, but now we have a weapons system consisting of the rocket and the thermonuclear bomb which have made war unacceptable.

Dr. Mebane pointed out that an attack by 240 such weapons on 240 key American cities would cause more than 45 million casualties and leave only 5 percent of our national production capacity usable.



Stritch School of Medicine graduates, class of 1916, were initiated into the Illinois State Medical Society's 50 Year Club at a luncheon on May 17. New members are, left, front row: Drs. M. Penchina, A. W. Summers, Noreen Marie Sullivan Doran, Edward Hans and Joseph Jaffe. Back row from left: Drs. Frank Gburczyk, E. F. Hay, F. B. Balmer, H. Swanburg and J. A. Kollar.

Index to Volume 129

Page 1-100 January
101-204 February
205-306 March
307-524 April
525-632 May
633-738 June

Absenteeism in industry (Smith) 225
Acidosis syndrome due to paraldehyde (Gailitis) 258
Afrin: See Oxymetazoline hydrochloride
Aged: See Geriatrics
Agustsson, M. H., jt. auth. See Baffes, T. G.
American Association of Medical Assistants scholarship loan program, 189
American Cancer Society, Illinois volunteers continue cancer tests, 73
American Medical Association
"Cutaneous Toxicity," new volume available, 284
ISMS in, president's page (Montgomery) 6
Illinois delegates to AMA, 405
what our Society does for us (Daro) 578
Amyloid, paraproteinemias (Griffin & Schwartz) 663
Aneurysm, false, of anterior tibial artery, the view box (Love) 686
Anorexia, depressive (Kraines) 569
Amniocentesis, prenatal diagnosis of hemolytic disease of newborn (Davidsohn) 39
Antibody activity, paraproteinemias (Griffin & Schwartz) 663
Appendix, 2 foreign bodies; screw and lead shot, case report (Maganini & Mathy) 137
Appetite, depressive anorexia (Kraines) 569
Arthritis: See also Rheumatoid Arthritis
placebo management of skeletal disease (Thrift & Traut) 683
Articles, preparing a paper on drug therapy (Kautz) 158

Baffes, T. G., and Agustsson, M. H., Maintenance of postoperative electrolyte balance in infants and small children without daily blood analysis, 339
Bence Jones Protein, paraproteinemias (Griffin & Schwartz) 561
Blood
glucose determination, routine for newborn infants (Kunstadter) 47
group incompatibility of newborn (Davidsohn) 39
paraproteinemias (Griffin & Schwartz) 561; 663
Blood Pressure, high: See Hypertension
Blood Transfusion, intrauterine, to prevent hemolytic disease of the newborn (Davidsohn) 41
Blood Vessels, peripheral, surgery, progress in (Polin) 345
Blue Cross subscribers, Medicare will affect 10%, 572
Bones, placebo management of skeletal disease (Thrift & Traut) 683
Bronchi, endobronchial lipoma, report of case; review of literature (Jablokow & Rubnitz) 57
Bronchoesophageal fistula, benign, associated with traction diverticulum of esophagus (Weissman & others) 127
Burns, unusual extensive thermal, treatment (Klinghoffer) 33

BOOK REVIEWS
Adler, F. H., Physiology of the Eye, 84
Bowers, J. Z., Medical Education in Japan, 280
Brodeur, A. E., Radiologic Diagnosis in Infants and Children, 718
Earle, A. S., ed., Surgery in America: From the Colonial Era to the Twentieth Century, 84
Ellis, E. H., Freisen, S. R., and Mulholland, J. H., Current Surgical Management III, 278
Faulconer, A., Jr., and Keys, T. E., Foundations of Anesthesiology, 182
Gaillard, P. J., Talmage, R. V., and Budy, A. M., ed., The Parathyroid Glands, 718
Kobak, M. W., Studies on the Abdominal Incision, 278
Meirowsky, A. M., ed., Neurological Surgery of Trauma, 84
Nealon, T. F., Jr., Management of Patient with Cancer, 498
Sawyer, P. N., ed., Biophysical Mechanisms in Vascular Homeostasis and Intravenous Thrombosis, 186
Schaffer, A. J., Diseases of the Newborn, 498
Spratt, J. S., Shieber, W., and Dillard, B. M., Anatomy and Surgical Technique of Groin Dissection, 182
Wilson, T. H., Intestinal Absorption, 498

Carcinoma
Illinois volunteers continue cancer tests, 73
of right upper lobe of lung, the view box (Love) 167
Casella, P. A., jt. auth. See Khedroo, L. G.
Chesrow, Eugene J., M.D., tribute to, in upgrading Oak Forest Hospital (Fonda) 352
Chicago
"Operation Head Start," results (Kravitz) 590
program for Negro physicians on hospital staffs in (Marciniak) 333
Chicago Medical Society, what our Society does for us (Daro) 578
Children: See also Infants
Is attendance at a private school medical treatment? (Nathan; Muchin) 669
maintenance of postoperative electrolyte balance in small children without daily blood analysis (Baffes & Agustsson) 339
"Operation Head Start" in Chicago (Kravitz) 590
tuberculin skin testing, statement on, 452
Chlorpropamide (Diabinese), long-term study of diabetics treated with (Doenges, Knox & Harrison) 25
Chronic Disease
Home Care Association of St. Clair County (Scrivner) 558
story of Oak Forest Hospital (Fonda) 352
Clinical Medicine, liver functions in (Steigmann) 139
Cold, gastric hypothermia to control gastric hemorrhage (Schwerin) 146
Cooley, J. C., jt. auth. See Weissman, I.
Curtin, J. W., Basic plastic surgical principles in repair of facial lacerations, 657
Cyclophosphamide (Cytoxan)
lymphoma treated with human tissue antisera (Greenspan) 549
treatment of Kaposi's idiopathic hemorrhage sarcoma (Spencer) 252
Cytoxan: See Cyclophosphamide

Daro, A. F., What our Society does for us, 578
Davidsohn, I., Blood group incompatibility of the newborn, 39
DeKalb County, analysis of opinions toward mental health among nurses and physicians (Frank & Powell) 579
Depression, anorexia (Kraines) 569
Diabetes Mellitus
non-diabetic ketosis in, during late pregnancy (Rony) 243
treated with chlorpropamide, long-term study (Doesges, Knox & Harrison) 25
Diabinese: See Chlorpropamide
Dideoct, J. W., and Wolf, R. L., Sporotrichosis, 31
Diet control, role in longevity (Long) 573
Doenges, J. P., Knox, L. J., and Harrison, C. W., A long-term study of diabetics treated with chlorpropamide, 25
Drugs
addiction: See Narcotics addiction
new regulations over depressant and stimulant drugs, 297
therapy, preparing a paper on (Kautz) 158
Duodenum, stretched out, in incarcerated diaphragmatic hernia (Raymond) 556

Eczema, vaccinatum, treated with Vaccine Immune Globulin (McEnery) 678
Electrolyte balance, postoperative, maintenance in infants and small children without daily blood analysis (Baffes & Agustsson) 339
Emergency Room theme of joint conference sponsored by ISMS and Illinois Hospital Association, 282
Esophagus, varices of upper one-third, the view box (Love) 55
Exercise, role in longevity (Long) 573

Face, basic plastic surgical principles in repair of facial lacerations (Curtin) 657
Falls, H. C., Discussion of Pollard and Wilson's article on treatment of hypertension in pregnancy, 155
Fees, ISMS committees on, 419; 420
Ferenzi, G. W., jt. auth. See Thompson, W. R.
Fistula, bronchoesophageal, benign, associated with traction diverticulum of esophagus (Weissman & others) 127
Fluids, maintenance of postoperative electrolyte balance in infants and small children without daily analysis (Baffes & Agustsson) 339
Fonda, B., "The light here kindled": the story of Oak Forest Hospital, 352
Food intake, role in longevity (Long) 573
Foreign Bodies, two of the appendix: screw and lead shot (Maganini & Mathy) 137
Fox, G. E., jt. auth. See Herndon, R. F.
Frank, I., and Powell, M., Analysis of opinions toward mental health among nurses and physicians in DeKalb County, Illinois, 579
Franklin protein, paraproteinemias (Griffin & Schwartz) 561
Funk, Martin, reports on Project Vietnam Service (non-military), 510
Furacin: See Nitrofurantoin

Gailitis, R. J., Paraldehyde acidosis syndrome, 258
Gamma Globulin
paraproteinemias (Griffin & Schwartz) 561
"specific," treatment of lymphoma (Greenspan) 549
Gastrointestinal Tract secretions analysis to maintain postoperative electrolyte balance in infants and small children (Baffes & Agustsson) 339
Geriatrics
Home Care Association of St. Clair County (Scrivner) 558
ISMS Committee on Aging, report, 410
predicament of the aged (Kast) 132
massive bleeding peptic ulcer; mortality in the aged (Yap) 43
some thoughts on longevity (Long) 573
story of Oak Forest Hospital (Fonda) 352
Globulins
paraproteinemias (Griffin & Schwartz) 561; 663
vaccine immune (VIG) and smallpox vaccinations complications (McEnery) 678
Greenspan, I., Cases of lymphoma treated with human tissue antisera, 549
Griffin, R. S., and Schwartz, S. O., The paraproteinemias, 561; 663

Harrison, C. W., jt. auth. See Doenges, J. P.
Health Careers Council of Illinois report: Your stake in manpower (Shapiro) 180
Hearing tests, "Operation Head Start" in Chicago (Kravitz) 590
Hemolytic disease of newborn, diagnosis, prognosis and prevention (Davidsohn) 39
Herndon, R. F., and Fox, G. E., Polyneuropathy due to nitrofurantoin, 164
Hernia, acutely obstructed incarcerated paraesophageal hiatal (Raymond) 556
Hirsch, Edwin F., M.D., profile of, as a humanist (Levinson) 263
Hirsch, M. S., and Powell, R. D., Malaria—a continuing problem, 674
Hodgkin's Disease, treated with human tissue antisera (Greenspan) 549
Home Care Association of St. Clair County (Scrivner) 558
Hospitals, Negro physicians on staffs in Chicago (Marciniak) 333
Hursh, L. M., jt. auth. See Weissman, I.
Hypertension, treatment in pregnancy (Pollard & Wilson) 153; (discussion by Falls) 155
Hypothermia, gastric, to control gastric hemorrhage (Schwerin) 146

Illinois
Association of Professions, (Committee report) 436; (Liaison Committee to Interprofessional Council) 437
Bar Association, Medical-Legal Committee of ISMS liaison with, 430
Circuit Court judges, IMT Usage (chart) 431
College Medical School, 1843-1848, Jacksonville, role of Dr. Prince (Norbury) 584
Council of Voluntary Health Agencies, established, 401
DeKalb County, analysis of opinions toward mental health among nurses and physicians in (Frank & Powell) 579
Dept. of Mental Health, report, 389
Dept. of Public Aid, report, 388; (report of Medical Advisory Committee to) 411
Dept. of Public Health, report on, 387
Dept. of Registration and Education, ISMS Liaison committee, 432
Division of Vocational Rehabilitation, 390
Health Careers Council report: Your stake in manpower (Shapiro) 180; (ISMS Advisory Committee to, report) 460

Illinois—continued
Hospital Association, emergency room theme on joint conference with ISMS, 282
Medical Assistants Association, (report: success story) 90; (scholarship loan program) 189; (drug addiction study) 289; (ISMS Advisory Committee to, report) 459; (best for the patient is best for you) 506
Osteopathic Association, ISMS Liaison Committee to, 435
Pharmaceutical Association, ISMS liaison committee to, 435
St. Clair County, Home Care Association (Scrivner) 558
volunteers continue cancer tests, 73
Illinois Medical Journal
Committee, report, 438
Editor, report, 440
Illinois State Medical Society
Ad Hoc Committee on Special Problems of Medical Education, 449
Advisory Committee to the Health Careers Council of Illinois (Shapiro) 180; (report) 460
Advisory Committee to Illinois Medical Assistants Association, 459
Advisory Committee to Student AMA, 462
AMA delegation, 1966, 405
AMA relationship to, president's page (Montgomery) 6
Archives Committee, 403
Benevolence Committee, 405
Blue Cross-Blue Shield Liaison Committee, 414
Board of Trustees, abstracts of actions at meeting (January 15-16, 1966) 107; (March 12-13) 329
Board of Trustees, Chairman report, 383
Board of Trustees, Legislative Committee makes 8 recommendations, 78
budget, planning and programming, 401
budgets, 1965 and 1966, 398
Bylaws, changes considered, 407
Child Health Committee, 442
Committee on Aging, 410
Committee on Constitution and Bylaws, 407
Committee on Continuing Education, 443
Committee on Drug Manual, 413
Committee on Eye Health, 446
Committee on Fee Schedules, 419
Committee on Hospital Relations, 418
Committee on Laboratory Evaluation, 433
Committee on Medical Economics, 417
Committee on Medical Education, 447
Committee on Mental Health, 449
Committee on Narcotics and Hazardous Substances, 434
Committee on Nursing, 450
Committee on Nutrition, 450
Committee on Occupational Health, 432
Committee on Perinatal Mortality, 450
Committee on Prepayment Plans and Organization, 414
Committee on Public Relations, 454
Committee on Public Safety, 458
Committee on Quackery, 432
Committee on Radiation, 451
Committee on Rehabilitation Service, 413
Committee on Scientific Assembly, 440
Committee on Scientific Exhibits, 441
Committee on Standard Vital Certificates, 453
Committee on Usual and Customary Fees, 420
Committee structure outlined by Committee on Committees, 188
Committee to Study Committees, 392
Committee to Study the Convention, 441
Committees for 1966 House of Delegates, 368
Conference on Narcotic Addiction, March 24-25, 1966, (program) 178; 284
Constitution, changes considered, 407
county medical societies, report by districts, 374
Delegates' Handbook, 126th Convention, May 15-18, 1966, 361
Disaster Medical Care Committee, 461
Editorial Board, report, 438
Educational & Scientific Foundation, report, 407
Environmental Health Committee, report, 444
Ethical Relations Committee report, 393
Executive Administrator, report, 396, 400
Fifty Year Club Committee report, 460
Finance Committee, (new IBM billing procedures) 76; (reviews 1966 budget) 188
financial statements for 1965, 399-400
Grievance Committee report, 460
headquarters, staff planning conferences, 402
headquarters, staff, tribute to, 396
House of Delegates (Handbook for Annual Convention) 361; (list of members) 363; (agenda for 1966 meeting) 366; (committees) 368; (minutes) 395
IBM processing, 398; 402
Impartial Medical Testimony Committee, report, usage by Illinois Circuit Court judge, 430; 431
Joint Conference with Illinois Hospital Association discusses emergency room, 282
Leadership Conference, April 27-28 (Montgomery) 220; (to supersede Secretaries' Conference) 397
Legislative Committee, (makes 8 recommendations to Trustees) 78; (report) 422
Liaison committee to Illinois Osteopathic Association, 435
Liaison Committee to the Pharmaceutical Association, 435
Maternal Welfare Committee, 446
Medical Advisory Committee to Selective Service, 436
Medical-Legal Committee, 430
Medical Student Loan Fund Committee, 403
Medicine and Religion Committee, 463
members, communication with, 396
Membership Committee, report, 394
membership dues, billing and collecting, centralized, with IBM service bureau, 398; 402
membership statistics, 397-398
membership survey will re-state ISMS mission (Montgomery) 116, 402
Museum project, chief project of Archives Committee, 190; 403
1966 Annual Convention (Montgomery) 314; 361; (program summary) 467; (list of Scientific Exhibits) 477; (list of Technical Exhibitors) 482-483
Officers' reports, 371
Physicians' Placement Service, 88; 286; 457; 509; 617
Policy Committee, report, 391
President-Elect, report, 372
President's page (Montgomery) (ISMS in AMA) 6; (membership survey will restate ISMS mission) 116; (April leadership conference) 220; (Annual Convention) 314; (A look backward and a look forward) 532
President's page (Portes) (areas for attention) 644

Illinois State Medical Society—continued
President, report, 371
Public Affairs Committee (outlines plans for 1966) 190; 401; 428
resolutions to be considered, 464
Scientific Exhibits, 477
Secretaries' Conference, to be changed to Leadership Conference, 397
Secretary-Treasurer, report, 395
Speaker and Vice Speaker, report, 381
Tuberculosis Committee, (report of meeting, October 19, 1965) 76; (annual report) 451
Vice President, reports (1st) (Saxon) 373; (2nd) (Epsteen) 373
what our Society does for us (Daro) 578
Woman's Auxiliary: See Woman's Auxiliary
Immunoglobulins, paraproteinemias (Griffin & Schwartz) 561
Impartial Medical Testimony Committee, (report) 430; (chart showing usage by Circuit Court judges) 431
Industry, absenteeism in (Smith) 225
Infants
maintenance of postoperative electrolyte balance in (Baffes & Agustsson) 339
newborn, blood group incompatibility in (Davidsohn) 39
newborn, routine blood glucose determination for (Kunstadter) 47
Jablokow, V. R., and Rubnitz, M. E., Endobronchial lipoma: report of a case and review of literature, 57
Jacksonville, Illinois, David Prince, pioneer surgeon (Norbury) 584
Kast, E. C., Predicament of the aged, 132
Kautz, H. D., Preparing a paper on drug therapy: basic principles, 158
Ketosis, non-diabetic, in diabetes during late pregnancy (Rony) 243
Khedroo, L. G., and Casella, P. A., Acute hemorrhagic pancreatitis; beneficial effects of primary excision of grossly necrotic pancreatic tissue, 61
Kidneys, infarction, surgical ligation of renal artery with, the view box (Love) 357
Klinghoffer, M., Treatment of an unusual extensive thermal burn, 33
Knox, L. J., jt. auth. See Doenges, J. P.
Kraines, S. H., Depressive anorexia, 569
Kravitz, H., Medical progress
blood group incompatibility of the newborn (Davidsohn) 39
liver functions in clinical medicine (Steigmann) 139; 233
paraproteinemias, 561; 663
progress in peripheral vascular surgery (Polin) 345
Kravitz, H., Results of "Operation Head Start" in Chicago, 590
Kulis, J. C., Melanoma masquerading as a psychosomatic disorder, 582
Kunstadter, R. H., Routine blood glucose for new born infants, 47
Laser beams, misuse, health and injury aspects of, ISMS Environmental Health Committee report, 445
Leadership Conference, April 27-28 (Montgomery) 220; 397
Legislation, report of ISMS Legislative Committee on (federal) 422; (state) 428
Legs, false aneurysm of anterior tibial artery, the view box (Love) 686
Leukemia, chronic myelogenous, treated with human antisera (Greenspan) 549
Levinson, S. A., A profile of Dr. Hirsch as a humanist, 263
Lincoln Shrine Museum in old State Capitol Building in Springfield, Committee report, 190; 403
Lipoma, endobronchial, report of case and review of literature (Jablokow & Rubnitz) 57
Liver functions in clinical medicine (Steigmann) 139; 233
Long, N. G., Some thoughts on longevity, 573
Longevity, some thoughts on (Long) 573
Love, L., The view box
carcinoma of right upper lobe of lung, 167
false aneurysm of the anterior tibial artery, 686
neurofibromatosis, 567
renal artery stenosis, 267
surgical ligation of renal artery with infarction of kidney, 357
varices of upper one-third of esophagus, 55
Lungs
cancer of right upper lobe, the view box (Love) 167
endobronchial lipoma (Jablokow & Rubnitz) 57
Lymphoma treated with human tissue antisera (Greenspan) 549
McEnery, J. T., Smallpox vaccinations complications and vaccinia immune globulin (VIG) 678
Maganini, R. J., and Mathy, W., Two foreign bodies of appendix: case report, 137
Malaria—a continuing problem (Hirsch & Powell) 674
Manuscript: See Articles
Marciniak, E., Program for Negro physicians on hospital staffs in Chicago, 333
Mathy, W., jt. auth.: See Maganini, R. J.
Mayer, P. S., A prolonged acting topical nasal decongestant for various rhinitides, 230
Medical Assistants
best for the patient is best for you, 506
drug addiction studied by, 289
Illinois Association (report: success story) 90; (ISMS Advisory Committee to, report) 459
scholarship loan program for, 189
Medical Progress (Kravitz)
blood group incompatibility of newborn (Davidsohn) 39
liver functions in clinical medicine (Steigmann) 139; 233
paraproteinemias (Griffin & Schwartz) 561; 663
progress in peripheral vascular surgery (Polin) 345
Medical Testimony, impartial, Committee report, 430; (usage by Illinois Circuit Court judges: chart) 431
Medicare, implementations (by Board of Trustees) 401; (Legislative report) 424; 426; (will affect 10% of Blue Cross membership) 572
Medicine, satirists' war on (Rosenheim) 48
Melanoma masquerading as a psychosomatic disorder (Kulis) 582
Mental Depression: See Depression
Mental Disorders, patients refusing psychiatric treatment (Swanson) 247
Mental Health, analysis of opinions toward, among nurses and physicians in DeKalb County, (Frank & Powell) 579
Mental Retardation, is attendance at a private school medical treatment? (Nathan; Muchin) 669

Montgomery, B. E., President's page
The annual convention, 314
April leadership conference vital to our existence, 220
ISMS in AMA, 6
A look backward and a look ahead, 532
membership survey will re-state ISMS mission, 116
Muchin, A. B., Is attendance at a private school medical treatment? A lawyer's viewpoint, 669
Museum, ISMS project, 190; 403
Myeloma, paraproteinemias (Griffin & Schwartz) 561; 565; 663

Narcotics
addiction, ISMS Conference on, March 24-25, program, 178; 284
addiction studied by medical assistants, 289
Nathan, L., Is attendance at a private school medical treatment? A doctor's viewpoint, 669
Negro physicians on hospital staffs in Chicago, program for (Marciniak) 333
Neurofibromatosis, the view box (Love) 567
Neurosis, melanoma masquerading as (Kulis) 582
Nitrofurantoin (Furacin), polyneuropathy due to (Herndon & Fox) 164
Norbury, F. B., David Prince, pioneer surgeon, 584
Nose, prolonged acting topical nasal decongestant: oxymetazoline hydrochloride (Afrin) (Mayer) 230
Nurses, analysis of opinions toward mental health, in DeKalb County (Frank & Powell) 579

Oak Forest Hospital, story of (Fonda) 352
Obesity, longevity and (Long) 573
"Operation Head Start" in Chicago, results of (Kravitz) 590
Opinion Research Corporation, membership survey will re-state ISMS mission (Montgomery) 116; 402
Osteopaths, Illinois Osteopathic Association, ISMS Liaison Committee to, 435
Oxymetazoline hydrochloride (Afrin), prolonged acting topical nasal decongestant for various rhinitides (Mayer) 230

Pancreas, grossly necrotic tissue, excision for acute hemorrhagic pancreatitis (Khedroo & Casella) 61
Paper: See Articles
Paraldehyde acidosis syndrome (Gailitis) 258
Paraproteinemias (Griffin & Schwartz) 561; 663
Parker, W. G., Thoughts on psoriasis, 256
Patients
best for the patient is best for you, 506
refusing psychiatric treatment (Swanson) 247
Peptic Ulcer, massive bleeding, mortality in aged (Yap) 43
Physical Examination, "Operation Head Start" in Chicago (Kravitz) 590
Physicians
analysis of opinions toward mental health, in DeKalb County (Frank & Powell) 579
Negro, on hospital staffs in Chicago, program for (Marciniak) 333
Placement Service, openings, 88; 286; 457; 509; 617
practical politics for doctors, 282
Placebo management of skeletal disease (Thrift & Traut) 683
Placement Service, Physicians', openings, 88; 286; 457; 509; 617
Polin, S. G., Progress in peripheral vascular surgery, 345
Politics, practical, for doctors, 282
Pollard, J. W., and Wilson, T. R., Treatment of hypertension in pregnancy, 153
Polyneuropathy due to nitrofurantoin (Herndon & Fox) 164
Portes, Caesar, President's page: Areas for attention, 644
Postoperative: See under Surgery
Potassium iodide treatment of sporotrichosis (Didcoct & Wolf) 31
Powell, M., jt. auth. See Frank, I.
Powell, R. D., jt. auth. See Hirsch, M. S.
Pregnancy
hypertension in, treatment (Pollard & Wilson) 153; (discussion by Falls) 155
late, non-diabetic ketosis in diabetes during (Rony) 243
President's Page: See under Illinois State Medical Society
Prince, David, 1816-1889, pioneer surgeon (Norbury) 584
Professions, Illinois Association of Professions (Committee report) 436; (subcommittee) 437
Protein, paraproteinemias (Griffin & Schwartz) 561
Psoriasis, thoughts on (Parker) 256
Psychiatry, patients refusing psychiatric treatment (Swanson) 247

Raymond, S. W., Acutely obstructed incarcerated paraesophageal hiatal hernia, 556
Renal Artery
surgical ligation, with infarction of kidney, the view box (Love) 357
stenosis, the view box (Love) 267
Rh Factor, sensitization to, prevention of hemolytic disease of the newborn (Davidsohn) 39
Rheumatoid Arthritis
placebo management (Thrift & Traut) 683
sarcoidosis and (Thompson & Ferenzi) 239
Rhinitis, prolonged acting topical nasal decongestant for: oxymetazoline hydrochloride (Afrin) (Mayer) 230
Rony, H. R., Non-diabetic ketosis in diabetes during late pregnancy, 243
Rosenheim, E., Jr., The satirists' war on medicine, 48
Rubnitz, M. E., jt. auth. See Jablokow, V. R.

St. Clair County, Home Care Association of (Scrivner) 558
Sarcoidosis and rheumatoid arthritis (Thompson & Ferenzi) 239
Sarcoma, Kaposi's idiopathic hemorrhagic, cytoxan treatment (Spencer) 252
Satirists' war on medicine (Rosenheim) 48
Schools, private, is attendance at considered medical treatment (Nathan; Muchin) 669
Schwartz, S. O., jt. auth. See Griffin, R. S.
Schwerin, G. S., Control of gastric hemorrhage with gastric hypothermia, 146
Scrivner, W. C., Home Care Association of St. Clair County, 558
Selective Service, Medical Advisory Committee to, 436
Shapiro, M. I., Your stake in manpower, 180
Skeleton: See under Bones
Skin, "Cutaneous Toxicity" published by AMA and Society of Toxicology, 284
Smallpox vaccinations and vaccinia immune globulin (VIG) (McEnery) 678

Smith, D. J., Absenteeism in industry, 225
Spencer, M. C., Cytoxan treatment of Kaposi's idiopathic hemorrhagic sarcoma, 252
Sporotrichosis (Dideoet & Wolf) 31
Steigmann, F., Liver functions in clinical medicine, 139; 233
Stomach
hemorrhage, control with gastric hypothermia (Schwerin) 146
incarcerated, through a diaphragmatic hernia (Raymond) 556
Surgery
plastic, basic principles in repair of facial lacerations (Curtin) 657
postoperative electrolyte balance in infants and small children, maintaining (Baffes & Agnstsson) 339
Swanson, D. W., Patients refusing psychiatric treatment, 247

Thompson, W. R., and Ferenzi, G. W., Sarcoidosis and rheumatoid arthritis, 239
Thrift, C. B., and Traut, E. F., Further studies on placebo management of skeletal disease, 683
Tibial Artery, anterior, false aneurysm of, the view box (Love) 686
Tissue antisera, human, lymphoma treated with (Greenspan) 549
Traut, E. F., jt. auth. See Thrift, C. B.
Tuberculin skin testing of children, statement on, 452

United States Food and Drug Administration new regulations over depressant and stimulant drugs, 297
United States Steel Corporation, absenteeism in industry (Smith) 225
Urine analysis to maintain postoperative electrolyte balance in infants (Baffes & Agustsson) 339

Vaccinia Immune Globulin (VIG) for smallpox vaccinations complications (McEnery) 678
Varices of upper one-third of esophagus, the view box (Love) 55
Vascular: See Blood Vessels
Vechinski, T. O., jt. auth. See Weissman, I.
Vena Cava obstruction, varices of upper one-third of esophagus resulting from, the view box (Love) 55
Vietnam Service, Illinois doctor, Dr. Martin Funk reports on, 510
View Box (Love)
carcinoma of right upper lobe of lung, 167
false aneurysm of anterior tibial artery, 686
neurofibromatosis, 567
renal artery stenosis, 267
surgical ligation of renal artery with infarction of kidney, 357
varices of the upper one-third of the esophagus, 55
Vision tests, "Operation Head Start" in Chicago (Kravitz) 590

Weissman, I., Hursh, L. M., Cooley, J. C., and Vechinski, T. O., Benign bronchoesophageal fistula associated with a traction diverticulum of esophagus, 127
Wilson, T. R., jt. auth. See Pollard, J. W.
Wolf, R. L., jt. auth. See Dideoet, J. W.
Woman's Auxiliary, President, report, 382

Yap, E. T., Massive bleeding peptic ulcer mortality in the aged, 43

Obituaries

Agamy, Glen, 302
Alexander, Charles B., 628
Berghoff, Robert S., 96
Boggs, John D., 520
Brodie, Frederic W., 628
Brown, DeWitt T., 96
Caravelli, Anthony F., 96
Carmichael, Robert H., 96
Caveney, Martin W., 302
Coen, Hardin E., 200
Cohen, Carl L., 302
Cunningham, Thomas R., 736
Curry, Arthur B., 96
Derman, Arnold U., 628
di Ciro, Dominic, 520
Doud, Ray W., 302
Dubovy, Samuel S., 736
Dundulis, Tadeus, 200
Eichler, Theodore F., 628
Ellis, Edward K., 628
Finesilver, Ilia M., 302
Fleischli, Clarence A., 302
Frankel, Ester T., 302
Frey, Leopold, 736
Garrison, Frederick F., 96
Giese, Theodore G., 520
Goldberger, Sol M., 520
Goodman, Jacob A., 200
Grimm, Harold A., 520
Hebenstreit, Kenneth J., 201
Hedge, Harry M., 302
Henderson, Curtis, 201
Henry, Sylvester F., 628
Herry, J. Roscoe, 96
Hiles, Homer L., 201
Jablonowski, Alex J., 201
Jezisik, Raymond, 628
Johnson, Lester, 736
Johnson, Warren, 201
Kaddourah, Issam H., 736
Kaplan, Joshua S., 736
Keeton, Kenneth H., 96
Kent, Paul, 96
Kizliuskas, Ceslovas, 96
Knapp, Harry P., 628
Korkes, Ludwig, 302
Lackenbacher, Rudolph S., 302
Lane, Calvert H., 201
Lauman, Everett L., 302
Lavieri, Jack R., 520
Leaf, Hugh M., 736
Lewis, David I., 520
Liederman, Albert L., 302
Lundgoot, Lars E., 520
Lunn, Abraham E., 96
MacGregor, William C., 628
Madison, Burle B., 736
Marszalek, John A., 201
Matthews, Cora A., 628
McGinnis, William S., 628
McNertney, Francis D., 628
Melyn, John A., 302
Miller, Arthur E., 201
Miller, Julian A., 628
Moore, Franklin J., Sr., 201
Morris, Theodore J., 96
Nakutny, Michael, 96
Orvis, Howard A., 302
Pallasch, Gervaise P., 201
Parker, Harry J., 201
Partipilo, Anthony V., 201
Petrone, Marco, 736
Phipps, Orvan A., 736
Pollock, William J., 628
Popuch, Louis D., 96
Potter, Charles A., 520
Pribyl, Augustin, 201
Rackus, Alexander M., 201
Restarski, Alvin F., 201
Robertson, Oswald H., 628
Rosson, James K., 302
Schroeder, F. W., 736
Seidler, Ferdinand, 302
Shea, Robert E., 201
Shnaper, Samuel, 201
Siegel, Eli, 96
Sloman, Sophie, 520
Smith, Milton L., 302
Somerville, William, 302
Spector, Israel H., 736
Storner, Frederick W., Jr., 302
Sylvester, Frank M., 628
Testin, Henry S., 96
Thimsen, Udell, 96
Thometz, Frank, 736
Tyllas, Harry A., 736
Vehe, Karl L., 201
Walgren, Roy L., 736
Weiss, Arthur M., 201
Wickster, George Z., 736
Wiesman, Irvin, 628
Williamson, Carl S., 736
Williamson, Maurice R., 302
Wishingrad, Lester, 520
Woehlk, Herman J. H., 302
Wright, Frank, 201
Wright, Harry, 302
Zidek, Emil R., 628



Dr. SIMS in ACTION

ADMINISTRATIVE AND COMMITTEE ACTIVITIES
OF THE ILLINOIS STATE MEDICAL SOCIETY

June, 1966

Medical Advisory Committee Meets with Swank

The State Medical Advisory Committee to the Illinois Department of Public Aid met with the Department on March 12. Mr. Swank discussed the possibility of using carriers as fiscal administrator for the medical assistance program in Illinois. This move is still in the stages of exploration but he expects a decision within 60 days, at which time a Committee meeting will be called.

He also discussed payments to hospitals, nursing homes and physicians, and stated that big adjustments in physicians' fees are on the horizon but he is waiting for regulations from the Department of Health, Education and Welfare before he proceeds.

It was reported to the Committee that the Department of Public Aid is confronted with the problem that some county committees are not functioning. It was brought to the Committee's attention that the Macon County Medical Advisory Committee advised the Department's staff in 1965 that it would henceforth recommend payment of all physicians' statements as submitted and has recently refused to review a sizeable number of bills submitted to it by the Department.

Maternal Welfare Committee Considers Abortion Laws

The Maternal Welfare Committee of the Illinois State Medical Society convened March 27. The first order of business was the review of the Cook County Hospital cases as presented by Dr. Augusta Webster and her staff.

Following this, the Committee considered the subject of liberalizing the abortion laws in Illinois, which subject was tabled at the last meeting. Dr. Diamond, Loyola University, pointed out the difficulties of making a diagnosis of rubella along with the fact that the risk of danger from rubella, particularly in the last month of the first trimester, has been grossly misunderstood and exaggerated. Dr. Diamond then discussed the problems of discovering other causes of fetal anomalies prospectively, along with some general remarks relative to the experiences of other areas in the field of abortion.

It was moved by Dr. Harry Lewis and seconded by Dr. William W. Curtis that the Committee on Maternal Welfare favors a change in the existing Illinois law pertaining to abortions to liberalize the condition under which an abortion may be performed when recommended by an appropriate committee in an accredited hospital.

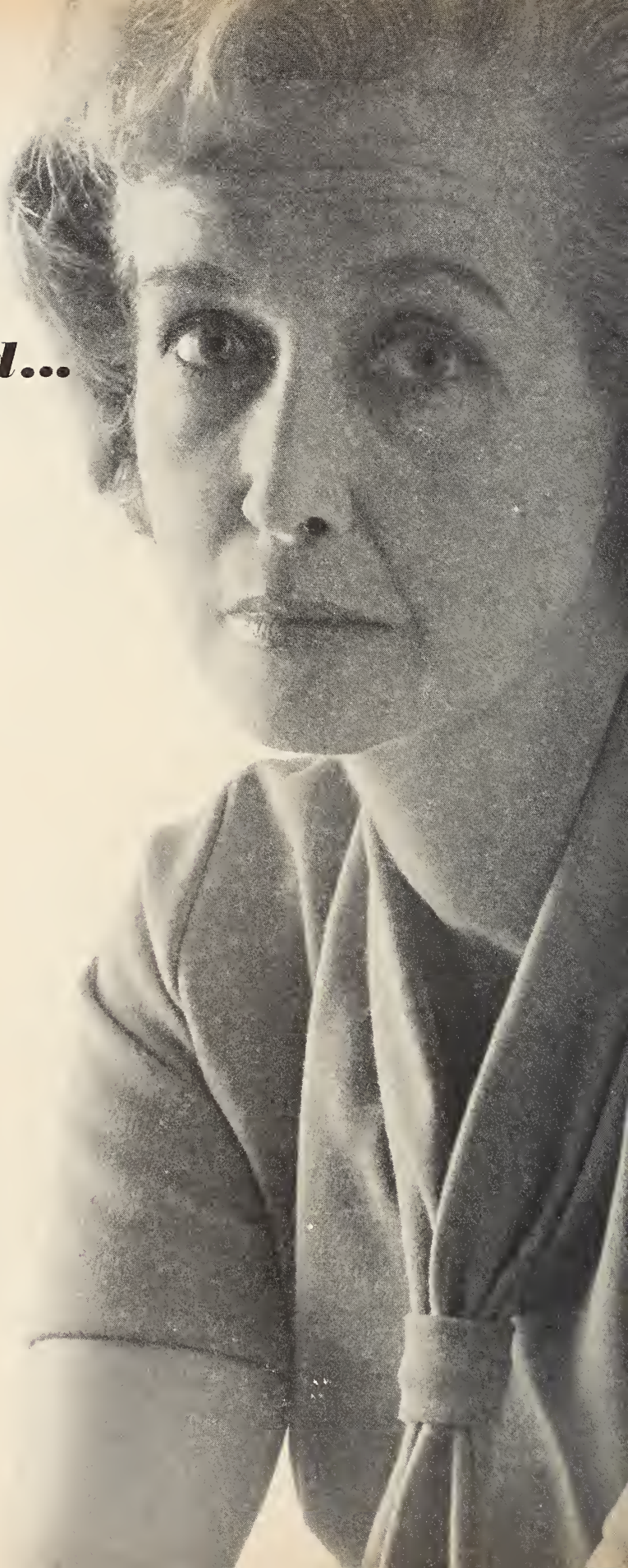
Lasers and Food Sanitation Covered by Committee on Environmental Health

The Committee on Environmental Health of the Illinois State Medical Society met recently to discuss the use of Laser beams and food sanitation within the state.

As a result of the increasing use of Laser beams in medical, industrial and educational applications, several accidents have occurred. It is felt that in order to prevent an increase in these accidents and to reduce the health hazards that occur

. . . continued on page 715

too young
to be so tired...





ons and adverse reactions: The transitory drowsiness ay occur with hydroxyzine HCl usually disappears span- y in a few days with continued therapy, ar is correctable ge reductian. Dryness af the mauth may be seen with lases. Invaluntary motor activity, including rare instances r and canvulsions, has been reparted, usually on higher ommended dasage. Hydraxyzine HCl may patentiate bar- , narcotics such as meperidine, and other CNS depres- conjunctive use, dosage for these drugs should be de- Because drawsiness may occur, patients shauld be cau- gainst driving o car or aperating dangerous machinery. **al Solution Precautions and contraindications:** This das- n is intended anly for I.M. ar I.V. administration and ot under ony circumstances be injected subcutaneously or erially. When the usual precautians far I.M. injection en followed, reports of soft tissue reactions have been e ta infrequent phlebitis and, rarely, reversible hemalysis naglabinuria, resulting fram taa rapid intravenous admin- of the salutian, I.V. administration shauld be slow, na an 25 mg. per minute, ond shauld not exceed 100 mg. in le dase. Particular care should be used to insure injec- y into intact veins; a few instances of digital gangrene g distal to the injectian site have been attributed ta inad- ntra-arterial injectian or periarteriol extravasatian, bath shauld be ovoided. **Use in Pregnancy:** When adminis- rats at high dasage, hydraxyzine induced fetal abnor- Until human clinical data is available adequate to safety in eorly pregnancy, hydroxyzine is cantraindi- early pregnancy. Use of hydroxyzine os an adjunct to the ment of labor has been extensively reparted in the litera- out evidence af harm to the mother ar fetus.

DR. SIMS IN ACTION

. . . *continued from page 711*

from aceidental misuse or lack of proper preeautions it would be desirable to prepare a statement describing the types of hazards and suggested preeautions to be observed. It was agreed that such a statement be prepared and distributed through the customary channels.

Dr. Edward Press, Chairman, reported that the State Department of Public Health, now responsible for food sanitation within the state, is desirous of revising the statutes governing this aetivity. The current Sanitary Inspection Law dates back to 1911 and has no provision that requires prospective proprietors of food serviee establishments to contact the Department of Public Health. There is no licensing or permit provisions so that any individual can open a food serviee establishment without regard to the type of facilities, plumbing, equipment, personnel, etc. In other words, unless such an establishment is located in an area that already has an ordinance requiring a permit or license prior to opening for business, the State Department of Public Health would not know about it until after they had already been open for business for some time. It would be much more preferable if the Department could advise individuals as to the requirement that would need to be met *before* they invested time, equipment and personnel and before they start serving the public rather than waiting until after a possibly sub-marginal and undesirable operation has started. Accordingly, a motion was approved to revise the Sanitary Inspection Law by up-dating it and by requiring a permit or license prior to the time the establishment opens for business. A draft of the proposed revision of the statutes will be prepared and submitted to the Committee for eonsideration. Following this it will be referred to the Committee on Legislation.

The Department has also received a number of reports from county department staff that local physicians are unwilling to continue providing services to public aid recipients unless or until fees for services are increased. As a result, some recipients must travel long distances from their communities to obtain medical care.

SECOND ANNUAL COACHES ATHLETIC INJURY CLINIC

Sponsored by the Illinois High School Coaches Association, the Illinois State Medical Society and the Athletic Association of the University of Illinois

SATURDAY, AUGUST 13, 1966

UNIVERSITY OF ILLINOIS ICE RINK, CHAMPAIGN

No Registration Fee

Open to Athletic Directors, Coaches, Trainers, Physicians and Therapists

PROGRAM

8:00—8:45 a.m.: Registration

8:45—9:00 a.m.: Welcome
Mr. Elliot, Dr. Fullerton

9:00—9:30 a.m.: General Aspects of Injury; Prevention by Conditioning
Prof. Shelton, Dr. Hamilton

9:45—10:15 a.m.: Insurance Liability and Responsibility—Panel Discussion

10:15—10:45 a.m.: The Ankle
Dr. Hamilton, Mr. Nicolette and Dr. Millhouse

10:45—11:00 a.m.: Break-Demonstrations—Faculty

11:00 a.m.—12:00 noon: Head and Neck
Dr. McCaskill

12:00—1:00 p.m.: Lunch

1:00—1:45 p.m.: Heat Illness
Dr. Hamilton, Mr. Nicolette and Dr. Fullerton

1:45—2:00 p.m. Break—Demonstrations
Faculty

2:00—2:40 p.m.: The Knee
Dr. Hamilton, Mr. Nicolette and Dr. Millhouse

2:40—3:40 p.m.: Abdominal and Genito-Urinary Injuries
Dr. Wiggishoff and Dr. Fullerton

3:40—4:30 p.m.: Physical Treatment Agencies—Faculty

4:30 p.m.: Open End Panel
Faculty

(In each break there will be practical demonstrations of exercise routines, tape and wrap of the ankle, knee, shin splints, shoulder and specifically of other common injuries.)

FACULTY

H. J. Blackwell, *USAF Ret., Assistant Trainer, University of Illinois, Urbana*

James C. Descourouez, *Head Trainer, Instructor in Physical Education, University of Illinois, Chicago Circle*

W. W. Fullerton, M.D., *Physician and Surgeon, Sparta*

R. C. Hamilton, M.D., *Orthopedic Surgeon, Chicago*

Daniel McCaskill, M.D., *Neurosurgeon, Champaign*

Edward Millhouse, Ph.D., *Anatomist, Chicago*

Robert J. Moore, R. P. T., *Assistant Trainer, University of Illinois, Urbana*

R. L. Nicolette, *Head Trainer, University of Illinois, Urbana*

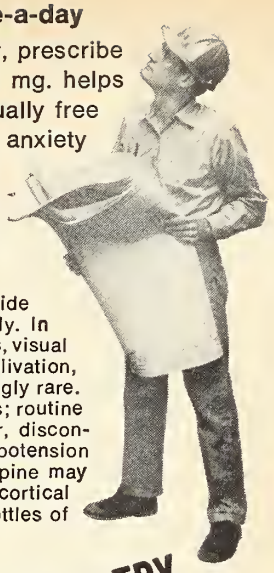
Robert E. Shelton, *Professor of Physical Education, Director, Exercise Therapy Clinic, University of Illinois, Urbana*

C. C. Wiggishoff, M.D., *Urological Surgeon, Evanston*

Ray Eliot, *Associate Professor of Physical Education, Assistant Director of Athletics, Former Head Football Coach, University of Illinois, Urbana*

Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

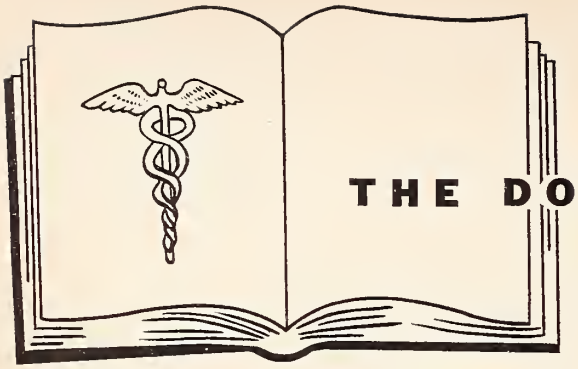
PROLIXIN®

THE SQUIBB TRANQUILIZER

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB

Squibb Quality — the Priceless Ingredient



THE DOCTOR'S LIBRARY

RADIOLOGIC DIAGNOSIS IN INFANTS AND CHILDREN. By Armand E. Brodeur. C. V. Mosby Company, 1965.

This 500-page volume is an inclusive but necessarily panoramic view of pediatric radiology. The presentation is orderly and considers a number of entities in prose as well as some diagrammatic descriptions and excellent radiographic reproductions.

Brodeur's book is easy to read, even though some chapters, such as those on the mandible and teeth, are quite detailed. The most useful function of the book is for the training of radiology residents. It would also serve as a useful reference book for the practicing radiologist or pediatrician.

Little description of special technique and angiography is considered.

The book serves a useful purpose for any reader in that its enumeration of many disease entities serves as a reminder and easy reference for consideration of pediatric radiographic problems. It also cleverly discusses pitfalls in diagnosis of which all of us should be reminded.

William L. Schey, M.D.

PRINCIPLES OF PATHOLOGY, 2nd Edition. By Howard C. Hopps, M.D. Appleton-Century Crofts, 403 pages. $8.95, 1964.

Principles of Pathology is a book primarily for the student. On the surface it appears to be elementary but after reading several chapters it is apparent that the author has made complicated and complex material descriptive and understandable. The margins of every page contain simple drawings that greatly clarify the material.

This second edition includes many more topics and drawings than the first. The author is now the Chief of the Division of Geographic Pathology of the Armed Forces Institute of Pathology. He is well qualified to write this unusual book having been Professor and Chairman of the Pathology Departments of the University of Oklahoma from 1944 to 1957 and of the University of Texas from 1957 to 1964.

T. R. Van Dellen, M.D.

THE PARATHYROID GLANDS: ULTRASTRUCTURE, SECRETION, AND FUNCTION, 1st Edition, by Pieter J. Gaillard, Roy V. Talmage and Ann M. Budy, Editors. 353 pages. The University of Chicago Press, Chicago and London, 1965. $15.00.

This book is the proceedings of the second parathyroid symposium, held in the Netherlands in 1964. It consists of 23 papers divided into seven sections. One section deals with the fine structure of the parathyroid glands, one with parathyroid hormone, one with hypocalcemic factors produced by the parathyroid glands (calcitonin), and four sections deal with the mode of action of parathyroid hormone on tissues, cells and metabolic pathways. The discussion at the end of each section helps to unify the papers as well as to summarize information and to bring out significant points of agreement and disagreement.

Primarily for those interested in parathyroid research, the book has the merit of collecting the latest information in one volume, no small feat when one considers the recent research explosion in this area. Research has changed our ideas of the action of parathyroid hormone, which we now think has a direct calcemic effect as well as a phosphaturic effect. It has become apparent that there is a second hormone with a blood calcium-lowering effect, called calcitonin, and in the symposium it was brought out that a similar hormone may be produced by the thyroid. Elegant methods of parathyroid assay were discussed. Hormonal effects at cellular and subcellular levels were described, and the problem of the relationship to vitamin D was brought out. It is apparent that the complex phenomena of calcium homeostasis are as yet not well understood. The symposium apparently furnished as many unsolved questions as it did answers, and it is important that these gaps in our knowledge be revealed.

As in all symposia, the problem of editing and unifying a group of independent papers exists, and the editors have solved this problem as well as could be expected.

Joseph C. Sherrick, M.D.

Thanks to Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

she can say "No thank you" to the crêpes suzette.

'Dexamyl' does more than most anorectics. Because it curbs appetite *and* lifts mood, 'Dexamyl' can encourage the discouraged dieter to stay on her diet.

The mood lift with 'Dexamyl' can make the difference between the success or failure of her diet plan.

Formulas: Each 'Dexamyl' Spansule® Capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

Smith Kline & French Laboratories SK&F



ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT

"FORWARD LOOK" FOR IMAA

"The Forward Look" was the theme of the 10th annual meeting of the Illinois Medical Assistants Association, held in Bloomington, Illinois, April 22-24, and attended by 162 registrants.

The convention was hosted by the McLean County Chapter, with Marilyn Knuth acting as convention chairman.

The highlight of the House of Delegates meeting was the election of the 1966-67 officers. They are: Sue Karels (Cook County), President; Mrs. Synobia Payne (Cook County), President-Eleet; Mrs. Ilene Herrell (DuPage County), First Vice-President; Mrs. Loretta Gaughran (Adams County), Second Vice-President; Miss Ruth Slater (Cook County), Recording Secretary; Mrs. Luella Mitchell (Cook County), Corresponding Secretary; and Mrs. Dorothy Stoffel (McHenry County), Treasurer.

In accordance with the IMAA objective of self-improvement, a well-rounded educational program was presented, including an "Explanation of Medicare Procedures" by Mr. Lee Forest of the Bureau of Health Insurance. He outlined the basic coverage, the supplemental package, the exclusions, the billing techniques and the basis of payment.

Mr. Robert Marr, Jr. of Smith Kline and Freneh, spoke on "The Hidden Sickness" which he defined as drug misuse or drug abuse as distinguished from drug addietion.

"The Tension State" was the topic of an illustrated lecture by Dr. A. Edward Livingston, president of the Society of Internal Medicine. He described the symptoms of tension and the causes of prolonged periods of tension in some patients, as well as the harm that such tension could cause in bringing on other diseases, such as peptic ulcer, headaches and essential hypertension.

The speaker for the Installation Banquet was Dr. Caesar Portes, President-Elect of the Illinois State Medical Society. Dr. Portes spoke on "Progress in Medicine," indicating the many things we take for granted such as blood vessel surgery, brain surgery, penicillin, sulfa drugs and insulin, as well as a longer life expectancy. He drew attention to the three scourges that are still with us: heart disease, cancer and stroke; and outlined the three means of fighting them: researeh, treatment, and education and early detection.

Following Dr. Portes' address, the new officers were installed by Dr. Carl Clark, AMA Advisory Board Chairman. A new charter was granted to the Will-Grundy County, whieh has an initial membership of 10. The charter was presented to the new chapter president, Mrs. Shirly Kleinsehmidt, president of IMAA, 1965-66.



Rx Reviews

and New Products

Chronic Constipation Effectively Treated with Milk of Magnesia and Mineral Oil

An emulsion of milk of magnesia and mineral oil (Haley's M-O) provided effective relief to 93.3 per cent of 77 chronically constipated hospitalized patients, according to a report in *Clinical Medicine* (73:75, 1966).

The emulsion "proved to be a thoroughly acceptable remedy" in all respects, states Dr. Eduardo Montilla, associate clinical professor of medicine, University of Puerto Rico. An overwhelming proportion of patients showed good tolerance to the medication. Dr. Montilla says the percentage reporting such common constipation side effects as gas, cramps, fullness and nausea, "markedly declined during the three-month medication period."

All 77 patients tested were tubercular. Some, in addition, were cardiac, geriatric and hemorrhoid patients. Seventy-two of the 77 subjects—or 93.3 per cent—were satisfied with the degree of relief they obtained.

The dose preferred by 62 patients was one ounce twice a day, the remainder claiming more satisfactory results with a one-ounce dose in the evening only.

"The frequency of bowel movements of these chronically constipated patients was maintained at slightly over one per day for a period of three months with only an occasional report of a loose or watery stool. This contrasts with an average of more than two days between bowel movements in the premedication period," according to the investigator.

He notes that "no oil leakage was observed" during the three-month treatment with Haley's M-O.

The product is manufactured by the Glenbrook Laboratories Division of Sterling Drug Inc.

Disposable Gown Designed to Fit All Patients



A new disposable examination gown intended for one-time use by doctors' patients is available from Professional Disposable Products, Inc. Made of strong white facial tissue or water-proof, soft, white poly-plastic, it eliminates the expense of buying and laundering more expensive linen gowns. To facilitate medical examination, the gown opens at the front or back. They are cut to a full 30 inches by 44 inches with adjustable waist that ties to fit all patients.

In quantities of 800, the price is 13.5 cents each; and 17.7 cents per gown, if purchased in 50-lot quantities. Inquiries should be addressed to Professional Disposable Products, Inc., 22-28 South Sixth Avenue, Mount Vernon, N.Y. 10550.

NEWS and ANNOUNCEMENTS



Residency Opportunities Listed in New PHS Booklet

Opportunities for physicians to receive residency training in Public Health Service hospitals are described in a new illustrated booklet issued by the Service.

The hospitals have expanded their training programs and now have about 230 residency positions for physicians. Further expansion is planned. The training is offered in the general hospitals in Baltimore, Boston, Detroit, Galveston, New Orleans, Norfolk, San Francisco, and Seattle, and on Staten Island, New York; and in two large Indian hospitals in Phoenix, Ariz., and Gallup, N. Mex.

Physicians may specialize in anesthesiology, dermatology, general practice, internal medicine, obstetrics and gynecology, ophthalmology, orthopedic surgery, pathology, pediatrics, preventive medicine, radiology, surgery, or urology.

The 40-page booklet is entitled "Residencies for Physicians, Public Health Service Bureau of Medical Services," PHS Publication No. 1408. Single copies may be obtained free of charge from the Public Health Service, Department of Health, Education, and Welfare, Washington, D. C. 20201.

AMA Sponsors National Conference on Infant Mortality

A National Conference on Infant Mortality is being sponsored by the American Medical Association's Committee on Maternal and Child Care. The Conference will be held on August 12-13, 1966, at the Fairmont Hotel in San Francisco, California.

An open invitation to attend is being extended to chairmen and members of all state and county Maternal and Child Care; Perinatal and Maternal Mortality Committees; State Health Department Directors of Maternal and Child Health; medical school faculty members in Departments of Obstetrics and Gynecology, Pediatrics, and Preventive Medicine. Other interested physicians and representatives of groups concerned with the problems of infant mortality are also invited to attend.

The program has been planned to explore effective approaches for continuing the reduction of infant mortality. Special workshops will be arranged to discuss the identification of high risks, organization and delivery of special care services, manpower utilization, continuity of reproductive care and problems of prematurity. Other subjects to be covered by special speakers will include perinatal mortality studies, obstetric and pediatric education programs, research questions, expectant parent and sex education, and population control.

Those interested in receiving further information about registration for the Conference should write the Secretary, Committee on Maternal and Child Care, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Medical Missionary Program Planned

The American Medical Association's 115th Annual Convention in Chicago June 26-30, will feature a series of programs, over a four-day period, of special and general interest to the physician working or planning to work in the missionary field.

The AMA Department of Medicine and Religion is focusing attention on the programs in recognition of the recent increased involvement of American physicians in world-wide humanitarian work. The interest in this wark partially stems from the current, vigorous emphasis by U.S. religious groups on world health activities.

The programs will be of interest to the physician who donates his time and skill to medical missionary work on a short-time basis, as well as those who devote extended periods of time or their careers to such work, the AMA department said.

Included in the activities will be a reception, panel discussion and clinical programs.

On Monday, June 27, the medical missionaries will be able to attend the meeting of the AMA's Section on Military Medicine at which a series of papers will be presented by military physicians dealing with various health problems encountered in Southeast Asia and other tropical areas.

On Wednesday, June 29, a special reception will be held for medical missionaries and those interested in the medical missionary field. The reception will afford doctors an opportunity to meet contemporaries working in the medical missionary field and to meet officers of the AMA.

On Thursday, June 30, there will be an all-day clinical program on tropical diseases, presented by the Section on Physiology and Pathology.

The clinical program deals with "The Impact of Diseases of Southeast Asia on American Medicine" and is co-sponsored by the International Academy of Pathology.

Radio Station Plans Attack on Chicago Drug Addiction Problem

Radio Station WVON, Chicago, has joined the Illinois State Medical Society plan to wage all-out war against Chicago's growing drug addiction problem.

Roy Wood, news director of WVON, told the state medical organization that the station would wage an "all-out campaign to educate our community to the hazards and disasters that come from drug addiction.

"We plan to issue editorials, medical interview type programs, and use all the programming facilities at our command in an effort to bring this problem home to the Negro," Wood said.

Wood also said that in cooperation with the Illinois State Medical Society WVON would "carry the message directly into the

New Issue

The following offering is made by Prospectus only, where state laws permit.

$4,000,000

APACHE MID-YEAR OIL AND GAS PROGRAM 1966

400 PROGRAM UNITS

Offering price:
$10,000 PER UNIT

Also available:
$5,000 PER ½ UNIT

These securities represent pro rata interests in a diversified oil and gas drilling program. They are offered as a speculation.

APACHE OIL PROGRAMS, INC.



■ Minneapolis ■ Chicago ■ New York ■ Los Angeles
■ Dallas ■ Tulsa ■ Houston ■ Midland ■ Calgary

APACHE OIL PROGRAMS, INC.
1770 Foshay Tower, Minneapolis, Minn. 55402
Please send me the Prospectus on the Apache Mid-Year Oil and Gas Program 1966.
NAME:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
Telephone me at: _____ (Area Code) _____ (Number)

For a quick refreshing lift...



Fresh Up with 7-Up

7-Up Bottlers of Illinois



equal means equal

No more, no less – just equal.
That's the way the
handicapped want to be
considered for jobs – on an
equal footing with others.
No special favors, no
special roadblocks.
Just equal.
Hire the handicapped.
It's good business.

THE PRESIDENT'S COMMITTEE
ON EMPLOYMENT OF THE HANDICAPPED

schools, churches, and civic organizations of our community via special seminars, talks, movies, and anything else we can find to make this truly a people-to-people campaign."

WVON met recently with representatives of 10 organizations, sponsors of the recent Conference on Narcotic Addiction here. Other groups included ISMS, American Medical Association, U. S. Bureau of Narcotics, Illinois Pharmaceutical Association, Illinois Department of Mental Health, Illinois Division of Narcotic Control, Chicago Medical Society, Chicago Department of Mental Health, Council for the Understanding and Rehabilitation of Addicts, and Saint Leonard's House, to formulate various task forces to attack specific drug addition problems.

Chicago's drug addict population is reported to be the second largest in number in the nation, exceeded only by New York.

Twenty-three Clinics for Crippled Children Listed for July

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will count eighteen general clinics providing diagnostic, orthopedic, pediatric, speech, and hearing examination along with medical, social and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

July 6 Hinsdale—Hinsdale Sanitarium
July 7 Flora—Clay County Hospital
July 7 Sterling — Community General Hospital
July 7 Cairo—Public Health Building
July 8 Chicago Heights Cardiac — St. James Hospital
July 12 Peoria General—Children's Hospital

Continued on page 7

Symposium to Be of Interest to Physicians At Drug Information Association Meeting

A symposium with special interest for physicians and other persons oriented toward clinical medicine will be a part of the second annual meeting of the Drug Information Association in Chicago June 25-26.

Entitled "Development and Handling of Drug Information," the two-day symposium will consider such topics as: development of animal studies to plan human trials of drugs; acquiring human data before drugs are marketed; distribution of drug information by the pharmaceutical company; and evaluation and projection of drug information to the medical profession.

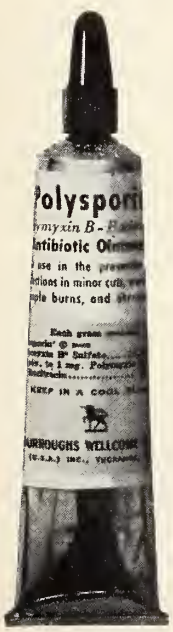
Participating in the symposium will be clinical investigators, pharmacologists, toxicologists, directors of medical research, information specialists, and others from U.S. and Canadian governmental regulatory agencies, pharmaceutical companies, and academic or other institutions. Serving as co-chairmen will be Jean K. Weston, M.D., Ph.D., director, and William Kitto, M.D., associate director, American Medical Association Department of Drugs.

The Drug Information Association meeting will be held in the Conrad Hilton Hotel.

Theme of the meeting as a whole is "Advances in Drug Information Processing." The Drug Information Association is a recently formed organization which held its first national meeting in October, 1965. Its membership consists of representatives of the Food and Drug Administration and other government agencies, the AMA and other medical or para-medical groups, pharmaceutical firms, and universities. Its purpose is to further modern technology of communication in medical, pharmaceutical and allied fields.

The program will include 30-minute contributed papers, invited presentation, and some audience-participation discussions. Registration fees are $20 for members of the Drug Information Association and $30 for non-members.

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand
POLYMYXIN B-BACITRACIN
ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: In ½ oz. and 1 oz. tubes
Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
Starting Dates — 1966

SPECIALTY REVIEW COURSE IN PEDIATRICS, September 26
SPECIALTY REVIEW COURSE IN MEDICINE, PART I, Sept. 12 and 26
SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 15
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
PROCTOSCOPY & VARICOSE VEINS, One Week, August 15
SURGERY OF TRAUMA, One Week, June 20
MANAGEMENT OF BURNS & SHOCK, Two Days, June 24 & 25
PRINCIPLES OF OPERATIVE SURGERY, Two Weeks, July 25
BASIC PRINCIPLES IN GENERAL SURGERY, Two Weeks, July 11
SURGERY OF STOMACH & DUODENUM, One Week, Sept. 19
FLUIDS AND ELECTROLYTES, One Week, September 12
VAGINAL SURGERY, One Week, June 20, August 15
GYNECOLOGY, Two Weeks, September 12
ADVANCED HEMATOLOGY, One Week, June 20
CLINICAL ENDOCRINOLOGY, One Week, June 13
PAIN RELIEF IN CHILDBIRTH, Three Days, July 6
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

TEACHING FACULTY
Attending Staff of
Cook County Hospital
Address: REGISTRAR, 707 South Wood Street
Chicago, Illinois 60612

underachievers

A residential facility for Junior and Senior High School males who need psychiatric help with: ■ Problems of academic underachievement and attendance . . . ■ Difficulties in family-school-social adjustments.
Complete academic and therapy program for grades 7 through 12.
For information contact: Rita Burgett, Secretary
The Readjustment Center
Box 373, Ann Arbor, Mich.
Phone: (AC 313) 663-5522



NEWS and ANNOUNCEMENTS *(cont'd)*

July 12 East St. Louis—Christian Welfare Hospital
July 13 Champaign - Urbana — Mckinley Hospital
July 13 Joliet—Silver Cross Hospital
July 14 Springfield General—St. John's Hospital
July 19 Quincy—St. Mary's Hospital
July 19 Danville—Lake View Hospital
July 20 Evergreen Park—Little Co. of Mary Hospital
July 20 Mt. Vernon — Good Samaritan Hospital
July 21 Rockford — Swedish - American Hospital
July 21 Decatur—Decatur & Macon Co. Hospital
July 21 Elmhurst Cardiac — Memorial Hospital of DuPage County
July 22 Chicago Heights Cardiac—St. James Hospital
July 26 Peoria General—Children's Hospital
July 27 Centralia—St. Mary's Hospital
July 27 Springfield Cerebral Palsy (P.M.) —Memorial Hospital
July 27 Elgin—Sherman Hospital
July 28 Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

Maxillofacial Surgeons Hold Annual Meeting

The American Society of Maxillofacial Surgeons will hold its annual meeting in Chicago, June 29-July 2.

The first session will be at McCormick Place on June 29, 1:30-4:30 p.m., in conjunction with the Annual Convention of the American Medical Association. Other sessions will be held at the Sheraton-Chicago Hotel.

All members of the medical profession are cordially invited to attend the lectures and functions.

Continued on page 7

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

CHICAGO OFFICE: Tom J. Hoehn and E. M. Breier, Representatives
55 East Washington Street, Room 1334, Chicago 60602 Telephone: 312-782-0990
MOUNT PROSPECT OFFICE: Theodore J. Pandak, Representative
709 Hackberry Lane (P. O. Box 105) Mount Prospect 60056 Telephone: 312-259-2774
ST. CHARLES OFFICE: Joseph C. Kunches, Representative
1220 Wing Avenue, St. Charles 60174 Telephone: 312-584-0920
SPRINGFIELD OFFICE: William J. Nattermann, Representative
1124 South Fifth Street, Springfield 62703 Telephone: 217-544-2251

Fully *Accredited*

NSH

North Shore Hospital

225 Sheridan Rd. **WINNETKA, ILLINOIS**

Care and treatment of emotional disorders

◆

for information contact:
Milton A. Dushkin, M.D.
MEDICAL DIRECTOR
Hillcrest 6-0211

Appointments

Dr. Alvin R. Tarlov of the University of Chicago has been named a John and Mary R. Markle Foundation scholar in academic medicine.

Dr. Tarlov is an Assistant Professor of Medicine at the University and at the Argonne Cancer Research Hospital, which is operated by the University on its campus for the U.S. Atomic Energy Commission.

The award carries with it a $30,000 grant, to be used over a five-year period to help support the recipient's medical research program and to aid in his development as a teacher and scientist.

Dr. Tarlov is conducting research on the membrane of red blood cells, and has been active in the biochemical identification of some inherited forms of anemia. His teaching is directed toward the integration of modern biology into the teaching of clinical medicine.

Dr. Tarlov received the B.A. degree from Dartmouth College in 1951 and the M.D. degree from the University of Chicago School of Medicine in 1956. He then served his internship at Philadelphia General Hospital and his residency at the Unisity of Chicago Clinics.

From 1958 until 1961, he was associated with the University of Chicago-Army Medical Research Unit at Stateville Penitentiary in Joliet, Illinois. He returned to the University of Chicago in 1962 as a Resident in Medicine. In 1963, Dr. Tarlov received a Research Career Development Award from the National Institute of Arthritis and Metabolic Diseases. He was on leave from the University of Chicago at Harvard Medical School's Department of Biologieal Chemistry in 1963 and 1964. In September, 1964, he was appointed to his present position at the University of Chicago.

Three faculty members from Chicago medical schools have been named winners of Lederle Medical Faculty Awards.

The winners are Dr. Nicholas V. Costea, Assistant Professor of Medicine at the University of Illinois Medical Center Campus in Chicago; Alexander H. Friedman, Assistant Professor of Pharmacology at Stritch School of Medicine of Loyola University; and Dr. John S. Thompson, Assistant Professor of Medicine at the University of Chicago.

The awards are given every year to medical school faculty members in the United States and Canada who have demonstrated outstanding capabilities both as medical teachers and as investigators. The winners receive up to $10,000 a year for periods of one to three years to supplement their salaries and for professional expenses.

An independent eommittee of medical educators selects the winners, and the awards are made by Lederle Laboratories of Pearl River, New York, a division of the American Cyanamid Company. The purpose of the program is "to sustain the high caliber of medical education in the United States and Canada and to help combat an estimated shortage of more than 700 teachers in U. S. medical schools."

Hospitalization For Emotionally Disturbed Patients

- MERCY HOSPITAL, Urbana, Ill., a not-for-profit general hospital, offers a Completely Modern, 30-bed Psychiatric Unit.
- The Unit is an evaluation & intensive treatment center, not intended for the care of the incurably mentally ill.
- It is equipped to offer more Intensive Care at Less Expense, Quickly Available Care, a Consultative Staff in Many Specialties, and has three Board-Qualified Psychiatrists on the Staff.
- All Physicians, staff and non-staff are invited to make psychiatric referrals.

For information concerning admission:

PSYCHIATRIC UNIT—MERCY HOSPITAL
1412 West Park Street, Urbana, Illinois
Area Code 217—Ph. 367-6621 Ex. 513

2 Approved Group Insurance Plans

for members of

THE ILLINOIS STATE MEDICAL SOCIETY

GROUP DISABILITY PLAN

TOTAL DISABILITY CAN BE COSTLY
Review Your Needs Today
Amounts Available up to
$250.00 Weekly

SPECIAL FEATURES

- SICKNESS BENEFITS TO AGE 65 PLAN
- THREE EXCELLENT PLANS TO CHOOSE FROM
- CONVERSION PLAN AVAILABLE AT AGE 70
- LOW RATES UNDER A TRUE GROUP POLICY

GROUP MAJOR MEDICAL PLAN

$15,000 MAXIMUM BENEFIT

Choice of 2 Deductibles

Dependent Coverage Available

Both IN and OUT of Hospital Expenses Included

Truly Catastrophic Protection

GROUP POLICY RATES

CALL OR WRITE

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance
ADMINISTRATORS

9933 LAWLER AVENUE SKOKIE, ILLINOIS PHONES 679-1000

Nervous
Geriatrics

Long Term and Short Term Care



Est. 1909

Mental
Custodial

Day Care and Mental Health Clinic

RESTHAVEN

This modernly equipped institution located in the beautiful Fox River Valley 35 miles west of Chicago, cooperates with physicians to the fullest extent.

It provides accommodations for 100 patients in single and double rooms. Resthaven accepts patients by referral and direct admission.

RESTHAVEN HOSPITAL, 600 VILLA ST., ELGIN, ILL.
Phone: SH 2-0327

OBITUARIES

Thomas R. Cunningham*, Chicago, died February 19, aged 59. He was a graduate of the Chicago State University School of Medicine in 1934 and specialized in obstetrics and gynecology.

Samuel S. Dubovy*, Chicago, died April 20, aged 78. He was a graduate of Loyola University School of Medicine in 1922.

Leopold Frey*, Chicago, died April 12, aged 70. He was a graduate of Medzinische Fakultat der Universitat Wieb, Vienna, in 1922.

Lester Johnson*, Casey, died May 4, aged 87. Dr. Johnson practiced in Casey for over 50 years until his recent retirement and had been associated with his two sons in the operation of the Johnson Clinic.

Issam H. Kaddourah*, Glen Ellyn, originally from Lebanon, died April 28, aged 41. He was a graduate of Faculte Francaise de Medecine et de Pharmacie de l'Universite Saint-Joseph, Beirut, in 1951. He was a staff member of Walthier, Gottlieb and Illinois Masonic Hospitals.

Joshua S. Kaplan, Chicago, died March 7, aged 75. He was a graduate of Loyola University Medical School in 1921.

Hugh M. Leaf*, Chicago, died April 4, aged 84. He was a graduate of Northwestern University School of Medicine in 1911.

Burle B. Madison*, Springfield, died December 12, aged 52. A graduate of the University of Illinois College of Medicine in 1928, he specialized in urology. He was an affiliate of St. John's Hospital.

Marco Petrone*, Chicago, died May 13, aged 64. He was a former professor of Gynecology at the Chicago Medical School and a former inspector for the City Health Department.

Orvan Abijah Phipps*, Manteno, died April 22, aged 83. He was a graduate of the University of Louisville School of Medicine in 1910. Dr. Phipps has served as chief of staff of St. Mary's Hospital, past president of the Kankakee County Medical Society and first president of the Kankakee County Heart Association.

F. W. Schroeder, Strasburg, died April 17, aged 83. He graduated from Concordia Theological Seminary, Springfield, in 1907, and practiced medicine in Sigel and Strasburg for 52 years, retiring in 1964.

Israel H. Spector*, Chicago, died April 25, aged 58. A graduate of Rusk Medical College in 1937, he specialized in psychiatry.

Frank P. Thometz*, Chicago, died February 4, aged 80. He was a graduate of the University of Illinois College of Medicine in 1908. He had been affiliated with the hospital of St. Anthony da Padua.

Harry A. Tyllas*, Chicago, died April 2, aged 59. In 1933 he was a graduate of the Chicago Medical School and specialized in occupational medicine.

Roy L. Walgren*, Pearl City, died April 27, aged 72. Before coming to Pearl City in 1934, Dr. Walgren practiced in Lena and Capron.

George Z. Wickster*, Oak Park, died May 2, aged 56. Dr. Wickster was a member of the Joint Maternal Welfare Committee of Chicago and a fellow of the American College of Surgeons. He was a past vice-president of the Aux Plaines Branch of the Chicago Medical Society, as assistant professor of obstetrics and gynecology at Loyola University's Stritch School of Medicine and a consultant at the St. Vincent Infant and Maternity Hospital.

Carl S. Williamson*, Danville, died April 16, aged 80. A graduate of the Chicago College of Medicine and Surgery in 1910, he specialized in colon and rectal surgery.

**Indicates member of Illinois State Medical Society.*



a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).

X67-609

Illinois medical journal.
v.129, 1966.

DATE	ISSUED TO

X67-609

Illinois medical journal.
v.129, 1966.

RETURN THIS BOOK ON OR BEFORE LAST DATE STAMPED

NOV 27 '68
MAY 5 '69
AUG 29 '69
SEP 23 '69
JUN 21 '71

RET'D. JUN 15 '71